DEPARTMENT OF DEFENSE
WASHINGTON HEADQUARTERS SERVICES
1155 DEFENSE PENTAGON
WASHINGTON, DC 20301-1155

April 14, 1995

MEMORANDUM FOR [redacted], DTIC-OCC

SUBJECT: Change 8 to the Reprint of DoD 6010.8-R, dated February 15, 1995

The attached Change 8 to the Reprint of DoD 6010.8-R, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," July 1991, is provided to DTIC. The DTIC accession number for the Reprint of the Regulation and Changes 1-4 to the Reprint is ADA-268034. The DTIC accession number for Change 5 to the Reprint is ADA-274483. The DTIC accession number for Change 6 to the Reprint is ADA-283216. The DTIC accession number for Change 7 to the Reprint is ADA-_____.

For further information, please contact me at (703) 697-4111 or -4112.

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DEPARTMENT OF DEFENSE
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CHANGE TRANSMITTAL

OFFICE OF THE SECRETARY OF DEFENSE
Assistant Secretary of Defense for Health Affairs

CHANGE NO. 8
to July 1991, Reprint
DoD 6010.8-R - CHG-8
February 15, 1995

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS). Change 8.

The Assistant Secretary of Defense for Health Affairs has authorized the following change to DoD 6010.8-R, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," July 1991 (Reprint).

PAGE CHANGE

Remove: Pages vii, 2-iii through 2-v, 2-13 through 2-26, 4-v through 4-ix, 4-42a through 4-55, 6-i&6-ii, 6-23 through 6-33, 14-i&14-ii, and 14-21 through 14-28

Insert: Attached replacement pages and new pages 2-27, 4-56 through 4-67, 6-34 through 6-36, 14-29 through 14-34, and 20-i through 20-7

Changes appear on pages vii, 2-iii through 2-v, 2-14, 2-25, 4-vi through 4-ix, 4-43 through 4-50, 6-ii, 6-25&6-26, 14-i&14-ii, 14-21 through 14-26, and 14-32 through 14-34

EFFECTIVE DATE

The above changes for Continued Health Care Benefit Program are effective immediately. Hospice Benefit changes are effective June 1, 1995.

Accesion For	
NTIS CRA&I	☒
DTIC TAB	☐
Unannounced	☐
Justification	
By	
Distribution /	
Availability Codes	
Dist	Avail and / or Special
A-1	

B.C. WHITEHEAD
Director
Correspondence and Directives

Attachments
89 pages

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, THIS TRANSMITTAL SHOULD BE FILED WITH THE BASIC DOCUMENT

SECTION Page

#Third Amendment (Ch 8, 2/15/95)

SECTION

#Fifth Amendment (Ch 8, 2/15/95)

#First Amendment (Ch 8, 2/15/95)

be covered under CHAMPUS as if FDA approved. Certain cancer drugs, designated as Group C drugs (approved and distributed by the National Cancer Institute) and Treatment Investigational New Drugs (INDs), cannot be cost-shared under CHAMPUS because they are not approved for commercial marketing by the FDA. However, medical care related to the use of Group C drugs and Treatment INDs can be cost-shared under CHAMPUS when the patient's medical condition warrants their administration and the care is provided in accordance with generally accepted standards of medical practice. NOTE: In areas outside the United States, standards comparable to those of the FDA are the CHAMPUS objective.

External Partnership Agreement. The external partnership agreement is an agreement between a military treatment facility commander and a CHAMPUS authorized institutional provider, enabling Uniformed Services health care personnel to provide otherwise covered medical care to CHAMPUS beneficiaries in a civilian facility under the Military-Civilian Health Services Partnership Program. Authorized costs associated with the use of the facility will be financed through CHAMPUS under normal cost-sharing and reimbursement procedures currently applicable under the basic CHAMPUS.

Extramedical Individual Providers of Care. Individuals who do counseling or nonmedical therapy and whose training and therapeutic concepts are outside the medical field, as specified in Chapter 6 of this Regulation.

Fraud. For purposes of this Regulation, fraud is defined as 1) a deception or misrepresentation by a provider, beneficiary, sponsor, or any person acting on behalf of a provider, sponsor, or beneficiary with the knowledge (or who had reason to know or should have known) that the deception or misrepresentation could result in some unauthorized CHAMPUS benefit to self or some other person, or some unauthorized CHAMPUS payment, or 2) a claim that is false or fictitious, or includes or is supported by any written statement which asserts a material fact which is false or fictitious, or includes or is supported by any written statement that (a) omits a material fact and (b) is false or fictitious as a result of such omission and (c) is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact. It is presumed that, if a deception or misrepresentation is established and a CHAMPUS claim is filed, the person responsible for the claim had the requisite knowledge. This presumption is rebuttable only by substantial evidence. It is further presumed that the provider of the services is responsible for the actions of all individuals who file a claim on behalf of the provider (for example, billing clerks); this presumption may only be rebutted by clear and convincing evidence.

Freestanding. Not "institution-affiliated" or "institution-based."

Former Spouse. A former husband or wife of a Uniformed Service member or former member who meets the criteria as set forth in paragraph B.2.b. of Chapter 3 of this Regulation.

Full-Time Course of Higher Education. A complete, progressive series of studies to develop attributes such as knowledge, skill, mind, and character, by formal schooling at a college or university, and which meets the criteria set out in Chapter 3 of this Regulation. To qualify as full-time, the student must be carrying a course load of a minimum of 12 credit hours or equivalent each semester.

General Staff Nursing Service. All nursing care (other than that provided by private duty nurses) including, but not limited to, general duty nursing, emergency room nursing, recovery room nursing, intensive nursing care, and group nursing arrangements performed by nursing personnel on the payroll of the hospital or other authorized institution.

Good Faith Payments. Those payments made to civilian sources of medical care who provided medical care to persons purporting to be eligible beneficiaries but who are determined later to be ineligible for CHAMPUS benefits. (The ineligible person usually possesses an erroneous or illegal identification card.) To be considered for good faith payments, the civilian source of care must have exercised reasonable precautions in identifying a person claiming to be an eligible beneficiary.

High-risk pregnancy. A pregnancy is high-risk when the presence of a currently active or previously treated medical, anatomical, physiological illness or condition may create or increase the likelihood of a detrimental effect on the mother, fetus, or newborn and presents a reasonable possibility of the development of complications during labor or delivery.

Hospice care. Hospice care is a program which provides an integrated set of services and supplies designed to care for the terminally ill. This type of care emphasizes palliative care and supportive services, such as pain control and home care, rather than cure-oriented services provided in institutions that are otherwise the primary focus under CHAMPUS. The benefit provides coverage for a humane and sensible approach to care during the last days of life for some terminally ill patients.

Hospital, Acute Care (General and Special). An institution that meets the criteria as set forth in paragraph B.4.a. of Chapter 6 of this Regulation.

Hospital, Long-Term (Tuberculosis, Chronic Care, or Rehabilitation). An institution that meets the criteria as set forth in paragraph B.4. of Chapter 6 of this Regulation.

Hospital, Psychiatric. An institution that meets the criteria as set forth in paragraph B.4. of Chapter 6 of this Regulation.

Illegitimate Child. A child not recognized as a lawful offspring; that is, a child born of parents not married to each other.

Immediate Family. The spouse, natural parent, child and sibling, adopted child and adoptive parent, stepparent, stepchild, grandparent, grandchild, stepbrother and stepsister, father-in-law, mother-in-law of the beneficiary, or provider, as appropriate. For purposes of this definition only, to determine who may render services to a beneficiary, the step-relationship continues to exist even if the marriage upon which the relationship is based terminates through divorce or death of one of the parents.

Independent Laboratory. A freestanding laboratory approved for participation under Medicare and certified by the Health Care Financing Administration.

Infirmaries. Facilities operated by student health departments of colleges and universities to provide inpatient or outpatient care to enrolled students. When specifically approved by the Director, OCHAMPUS, or a designee, a boarding school infirmary also is included.

Initial Determination. A formal written decision on a CHAMPUS claim, a request for benefit authorization, a request by a provider for approval as an authorized CHAMPUS provider, or a decision disqualifying or excluding a provider as an authorized provider under CHAMPUS. Rejection of a claim or a request for benefit or provider authorization for failure to comply with administrative requirements, including failure to submit reasonably requested information, is not an initial determination. Responses to general or specific inquiries regarding CHAMPUS benefits are not initial determinations.

In-Out Surgery. Surgery performed in the outpatient department of a hospital or other institutional provider, in a physician's office or the office of another individual professional provider, in a clinic, or in a "freestanding" ambulatory surgical center which does not involve a formal inpatient admission for a period of 24 hours or more.

Inpatient. A patient who has been admitted to a hospital or other authorized institution for bed occupancy for purposes of receiving necessary medical care, with the reasonable expectation that the patient will remain in the institution at least 24 hours, and with the registration and assignment of an inpatient number or designation. Institutional care in connection with in and out (ambulatory) surgery is not included within the meaning of inpatient whether or not an inpatient number or designation is made by the hospital or other institution. If the patient has been received at the hospital, but death occurs before the actual admission occurs, an inpatient admission exists as if the patient had lived and had been formally admitted.

Institution-Affiliated. Related to a CHAMPUS authorized institutional provider through a shared governing body but operating under a separate and distinct license or accreditation.

Institution-Based. Related to a CHAMPUS authorized institutional provider through a shared governing body and operating under a common license and shared accreditation.

Institutional Provider. A health care provider which meets the applicable requirements established by section B. of Chapter 6 of this Regulation.

Intensive Care Unit (ICU). A special segregated unit of a hospital in which patients are concentrated by reason of serious illness, usually without regard to diagnosis. Special lifesaving techniques and equipment regularly and immediately are available within the unit, and patients are under

continuous observation by a nursing staff specially trained and selected for the care of this type patient. The unit is maintained on a continuing rather than an intermittent or temporary basis. It is not a postoperative recovery room nor a postanesthesia room. In some large or highly specialized hospitals, the ICUs may be further refined for special purposes, such as for respiratory conditions, cardiac surgery, coronary care, burn care, or neurosurgery. For the purposes of CHAMPUS, these specialized units would be considered ICUs if they otherwise conformed to the definition of an ICU.

Intern. A graduate of a medical or dental school serving in a hospital in preparation to being licensed to practice medicine or dentistry.

Internal Partnership Agreement. The internal partnership agreement is an agreement between a military treatment facility commander and a CHAMPUS authorized civilian health care provider which enables the use of civilian health care personnel or other resources to provide medical care to CHAMPUS beneficiaries on the premises of a military treatment facility under the Military-Civilian Health Services Partnership Program. These internal agreements may be established when a military treatment facility is unable to provide sufficient health care services for CHAMPUS beneficiaries due to shortages of personnel and other required resources.

Item, Service, or Supply. Includes (1) any item, device, medical supply, or service claimed to have been provided to a beneficiary (patient) and listed in an itemized claim for CHAMPUS payment or a request for payment, or (2) in the case of a claim based on costs, any entry or omission in a cost report, books of account, or other documents supporting the claim.

Laboratory and Pathological Services. Laboratory and pathological examinations (including machine diagnostic tests that produce hard-copy results) when necessary to, and rendered in connection with medical, obstetrical, or surgical diagnosis or treatment of an illness or injury, or in connection with well-baby care.

Legitimized Child. A formerly illegitimate child who is considered legitimate by reason of qualifying actions recognized in law.

Licensed Practical Nurse (L.P.N.). A person who is prepared specially in the scientific basis of nursing; who is a graduate of a school of practical nursing; whose qualifications have been examined by a state board of nursing; and who has been authorized legally to practice as an L.P.N. under the supervision of a physician.

Licensed Vocational Nurse (L.V.N.). A person who specifically is prepared in the scientific basis of nursing; who is a graduate of a school of vocational nursing; whose qualifications have been examined by a state board of nursing; and who has been authorized legally to practice as a L.V.N. under the supervision of a physician.

Long-Term Hospital Care. Any inpatient hospital stay that exceeds 30 days.

Low-Risk Pregnancy. A pregnancy is low-risk when the basis for the ongoing clinical expectation of a normal uncomplicated birth, as defined by reasonable and generally accepted criteria of maternal and fetal health, is documented throughout a generally accepted course of prenatal care.

Management Plan. A detailed description of the medical history of and proposed therapy for a CHAMPUS beneficiary seeking benefits under the PFTH as set forth in Chapter 5 of this Regulation. A management plan must include, at a minimum, a diagnosis (either in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) or the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III)); detailed reports of prior treatment, family history, social history, history of handicapping condition, and physical examination; diagnostic test results; consultants (if any) reports; proposed therapeutic approach and modality (including anticipated length of time the proposed modality will be required); prognosis; problem list; and all inclusive current or anticipated monthly charges related to the proposed management plan. If the management plan involves the transfer of a beneficiary from a hospital or another inpatient facility, medical records related to that inpatient stay also are required as a part of the management plan documentation.

Marriage and Family Therapist, Certified. An extramedical individual provider who meets the requirements outlined in Chapter 6 of the Regulation.

Maternity Care. Care and treatment related to conception, delivery, and abortion, including prenatal and postnatal care (generally through the 6th post-delivery week), and also including treatment of the complications of pregnancy.

Medicaid. Those medical benefits authorized under Title XIX of the Social Security Act (reference (h)) provided to welfare recipients and the medically indigent through programs administered by the various states.

Medical. The generally used term which pertains to the diagnosis and treatment of illness, injury, pregnancy, and mental disorders by trained and licensed or certified health professionals. For purposes of CHAMPUS, the term "medical" should be understood to include "medical, psychological, surgical, and obstetrical," unless it is specifically stated that a more restrictive meaning is intended.

Medical Emergency. The sudden and unexpected onset of a medical condition or the acute exacerbation of a chronic condition that is threatening to life, limb, or sight, and requires immediate medical treatment or which manifests painful symptomatology requiring immediate palliative efforts to alleviate suffering. Medical emergencies include heart attacks, cardiovascular accidents, poisoning, convulsions, kidney stones, and such other acute medical conditions as may be determined to be medical emergencies by the Director, OCHAMPUS, or a designee. In the case of a pregnancy, a medical emergency must involve a sudden and unexpected medical complication that puts the mother, the baby, or both, at risk. Pain would not, however,

qualify a maternity case as an emergency, nor would incipient birth after the 34th week of gestation, unless an otherwise qualifying medical condition is present. Examples of medical emergencies related to pregnancy or delivery are hemorrhage, ruptured membrane with prolapsed cord, placenta previa, abruptio placenta, presence of shock or unconsciousness, suspected heart attack or stroke, or trauma (such as injuries received in an automobile accident).

Medically or Psychologically Necessary. The frequency, extent, and types of medical services or supplies which represent appropriate medical care and that are generally accepted by qualified professionals to be reasonable and adequate for the diagnosis and treatment of illness, injury, pregnancy, and mental disorders or that are reasonable and adequate for well-baby care.

Medical Supplies and Dressings (Consumables). Necessary medical or surgical supplies (exclusive of durable medical equipment) that do not withstand prolonged, repeated use and that are needed for the proper medical management of a condition for which benefits are otherwise authorized under CHAMPUS, on either an inpatient or outpatient basis. Examples include disposable syringes for a diabetic, colostomy sets, irrigation sets, and ace bandages.

Medicare. Those medical benefits authorized under Title XVIII of the Social Security Act (reference (h)) provided to persons 65 or older, certain disabled persons, or persons with chronic renal disease, through a national program administered by the DHHS, Health Care Financing Administration, Medicare Bureau.

Mental Disorder. For purposes of the payment of CHAMPUS benefits, a mental disorder is a nervous or mental condition that involves a clinically significant behavioral or psychological syndrome or pattern that is associated with a painful symptom, such as distress, and that impairs a patient's ability to function in one or more major life activities. Additionally, the mental disorder must be one of those conditions listed in the DSM-III.

Mental Health Counselor. An extramedical individual provider who meets the requirements outlined in Chapter 6 of this Regulation.

Mental Health Therapeutic Absence. A therapeutically planned absence from the inpatient setting. The patient is not discharged from the facility and may be away for periods of several hours to several days. The purpose of the therapeutic absence is to give the patient an opportunity to test his or her ability to function outside the inpatient setting before the actual discharge.

Mental Retardation. Subnormal general intellectual functioning associated with impairment of either learning and social adjustment or maturation, or both. The diagnostic classification of moderate and severe mental retardation relates to intelligence quotient (IQ) as follows:

1. Moderate. Moderate mental retardation IQ 36-51.
2. Severe. Severe mental retardation IQ 35 and under.

Missing in Action (MIA). A battle casualty whose whereabouts and status are unknown, provided the absence appears to be involuntary and the service member is not known to be in a status of unauthorized absence. NOTE: Claims for eligible CHAMPUS beneficiaries whose sponsor is classified as MIA are processed as dependents of an active duty service member.

Morbid Obesity. The body weight is 100 pounds over ideal weight for height and bone structure, according to the most current Metropolitan Life Table, and such weight is in association with severe medical conditions known to have higher mortality rates in association with morbid obesity; or, the body weight is 200 percent or more of the ideal weight for height and bone structure according to the most current Metropolitan Life Table. The associated medical conditions are diabetes mellitus, hypertension, cholecystitis, narcolepsy, pickwickian syndrome (and other severe respiratory diseases), hypothalmic disorders, and severe arthritis of the weight-bearing joints.

Most-Favored Rate. The lowest usual charge to any individual or third-party payer in effect on the date of the admission of a CHAMPUS beneficiary.

Natural Childbirth. Childbirth without the use of chemical induction or augmentation of labor or surgical procedures other than episiotomy or perineal repair.

Naturopath. A person who practices naturopathy, that is, a drugless system of therapy making use of physical forces such as air, light, water, heat, and massage. NOTE: Services of a naturopath are not covered by CHAMPUS.

Nonavailability Statement. A certification by a commander (or a designee) of a Uniformed Services medical treatment facility recorded on DD Form 1251, generally for the reason that the needed medical care being requested by a CHAMPUS beneficiary cannot be provided at the facility concerned because the necessary resources are not available.

Nonparticipating Provider. A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider that furnished medical services or supplies to a CHAMPUS beneficiary, but who did not agree on the CHAMPUS claim form to participate or to accept the CHAMPUS-determined allowable cost or charge as the total charge for the services. A nonparticipating provider looks to the beneficiary or sponsor for payment of his or her charge, not CHAMPUS. In such cases, CHAMPUS pays the beneficiary or sponsor, not the provider.

North Atlantic Treaty Organization (NATO) Member. A military member of an armed force of a foreign NATO nation who is on active duty and who, in connection with official duties, is stationed in or passing through the United States. The foreign NATO nations are Belgium, Canada, Denmark, France, Federal Republic of Germany, Greece, Iceland, Italy, Luxemburg, the Netherlands, Norway, Portugal, Spain, Turkey, and the United Kingdom.

Official Formularies. A book of official standards for certain pharmaceuticals and preparations that are not included in the U.S. Pharmacopeia.

Optometrist (Doctor of Optometry). A person trained and licensed to examine and test the eyes and to treat visual defects by prescribing and adapting corrective lenses and other optical aids, and by establishing programs of exercises.

Oral Surgeon (D.D.S. or D.M.D.). A person who has received a degree in dentistry and who limits his or her practice to oral surgery, that is, that branch of the healing arts that deals with the diagnosis and the surgical correction and adjunctive treatment of diseases, injuries, and defects of the mouth, the jaws, and associated structures.

Orthopedic Shoes. Shoes prescribed by an orthopedic surgeon to effect changes in foot or feet position and alignment and which are not an integral part of a brace.

Other Allied Health Professionals. Individual professional providers other than physicians, dentists, or extramedical individual providers, as specified in Chapter 6 of this Regulation.

Other Special Institutional Providers. Certain special institutional providers, either inpatient or outpatient, other than those specifically defined, that provide courses of treatment prescribed by a doctor of medicine or osteopathy; when the patient is under the supervision of a doctor of medicine or osteopathy during the entire course of the inpatient admission or the outpatient treatment; when the type and level of care and services rendered by the institution are otherwise authorized in this Regulation; when the facility meets all licensing or other certification requirements that are extant in the jurisdiction in which the facility is located geographically; which is accredited by the Joint Commission on Accreditation if an appropriate accreditation program for the given type of facility is available; and which is not a nursing home, intermediate facility, halfway house, home for the aged, or other institution of similar purpose.

Outpatient. A patient who has not been admitted to a hospital or other authorized institution as an inpatient.

Ownership or Control Interest. For purposes of Chapter 9.F.1., a "person with an ownership or control interest" is anyone who

1. Has directly or indirectly a 5 percent or more ownership interest in the entity; or

2. Is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds 5 percent of the total property and assets of the entity; or

3. Is an officer or director of the entity if the entity is organized as a corporation; or

4. Is a partner in the entity if the entity is organized as a partnership.

Partial Hospitalization. A treatment setting capable of providing an interdisciplinary program of medical therapeutic services at least 3 hours per day, 5 days per week, which may embrace day, evening, night and weekend treatment programs which employ an integrated, comprehensive and complementary schedule of recognized treatment approaches. Partial hospitalization is a time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, and structured clinical services within a stable therapeutic environment. Partial hospitalization is an appropriate setting for crisis stabilization, treatment of partially stabilized mental health disorders, and a transition from an inpatient program when medically necessary. Such programs must enter into a participation agreement with CHAMPUS, and be accredited and in substantial compliance with the standards of the Mental Health Manual of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (formerly known as the Consolidated Standards).

Participating Provider. A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider that furnished services or supplies to a CHAMPUS beneficiary
and that submits a CHAMPUS claim form and accepts assignment of the CHAMPUS determined allowable cost or charge as the total payment(even though less than the actual charge), whether paid for fully by the CHAMPUS allowable amount or requiring cost-sharing by the beneficiary (or sponsor). See Chapter 6.A.8. for more information on the Participating Provider.

Party to a Hearing. An appealing party or parties and CHAMPUS.

Party to the Initial Determination. Includes CHAMPUS and also refers to a CHAMPUS beneficiary and a participating provider of services whose interests have been adjudicated by the initial determination. In addition, a provider who has been denied approval as an authorized CHAMPUS provider is a party to that initial determination, as is a provider who is disqualified or excluded as an authorized provider under CHAMPUS, unless the provider is excluded based on a determination of abuse or fraudulent practices or procedures under another federal or federally funded program. See Chapter 10 for additional information concerning parties not entitled to administrative review under the CHAMPUS appeals and hearing procedures.

Pastoral Counselor. An extramedical individual provider who meets the requirements outlined in Chapter 6 of the Regulation.

Pharmacist. A person who is trained specially in the scientific basis of pharmacology and who is licensed to prepare and sell or dispense drugs and compounds and to make up prescriptions ordered by a physician.

Physical Medicine Services or Physiatry Services. The treatment of disease or injury by physical means such as massage, hydrotherapy, or heat.

Physical Handicap. A physical condition of the body that meets the following criteria:

1. Duration. The condition is expected to result in death, or has lasted, or with reasonable certainty is expected to last, for a minimum period of 12 months; and

2. Extent. The condition is of such severity as to preclude the individual from engaging in substantially basic productive activities of daily living expected of unimpaired persons of the same age group.

Physical Therapist. A person who is trained specially in the skills and techniques of physical therapy (that is, the treatment of disease by physical agents and methods such as heat, massage, manipulation, therapeutic exercise, hydrotherapy, and various forms of energy such as electrotherapy and ultrasound), who has been authorized legally (that is, registered) to administer reatments prescribed by a physician and who is entitled legally to use the designation "Registered Physical Therapist." A physical therapist also may be called a physiotherapist.

Physician. A person with a degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is licensed to practice medicine by an appropriate authority.

Physician in Training. Interns, residents, and fellows participating in approved postgraduate training programs and physicians who are not in approved programs but who are authorized to practice only in a hospital or other institutional provider setting, e.g., individuals with temporary or restricted licenses, or unlicensed graduates of foreign medical schools.

Podiatrist (Doctor of Podiatry or Surgical Chiropody). A person who has received a degree in podiatry (formerly called chiropody), that is, that specialized field of the healing arts that deals with the study and care of the foot, including its anatomy, pathology, and medical and surgical treatment.

Preauthorization. A decision issued in writing by the Director, OCHAMPUS, or a designee, that CHAMPUS benefits are payable for certain services that a beneficiary has not yet received.

Prescription Drugs and Medicines. Drugs and medicines which at the time of use were approved for commercial marketing by the U.S. Food and Drug Administration, and which, by law of the United States, require a physician's or dentist's prescription, except that it includes insulin for known diabetics whether or not a prescription is required. Drugs grandfathered by the Federal Food, Drug and Cosmetic Act of 1938 may be covered under CHAMPUS as if FDA approved.

#Third Amendment (Ch 8, 2/15/95)

NOTE: The fact that the U.S. Food and Drug Administration has approved a drug for testing on humans would not qualify it within this definition.

Preventive Care. Diagnostic and other medical procedures not related directly to a specific illness, injury, or definitive set of symptoms, or obstetrical care, but rather performed as periodic health screening, health assessment, or health maintenance.

Primary Payer. The plan or program whose medical benefits are payable first in a double coverage situation.

Private Duty (Special) Nursing Services. Skilled nursing services rendered to an individual patient requiring intensive medical care. Such private duty (special) nursing must be by an actively practicing registered nurse (R.N.) or licensed practical or vocational nurse (L.P.N. or L.V.N.) only when the medical condition of the patient requires intensive skilled nursing services (rather than primarily providing the essentials of daily living) and when such skilled nursing care is ordered by the attending physician.

Private Room. A room with one bed that is designated as a private room by the hospital or other authorized institutional provider.

Program for the Handicapped (PFTH). The special program set forth in Chapter 5 of this Regulation, through which dependents of active duty members receive supplemental benefits for the moderately or severely mentally retarded and the seriously physically handicapped over and above those medical benefits available under the Basic Program.

Progress notes. Progress notes are an essential component of the medical record wherein health care personnel provide written evidence of ordered and supervised diagnostic tests, treatments, medical procedures, therapeutic behavior and outcomes. In the case of mental health care, progress notes must include: the date of the therapy session; length of the therapy session; a notation of the patient's signs and symptoms; the issues, pathology and specific behaviors addressed in the therapy session; a statement summarizing the therapeutic interventions attempted during the therapy session; descriptions of the response to treatment, the outcome of the treatment, and the response to significant others; and a statement summarizing the patient's degree of progress toward the treatment goals. Progress notes do not need to repeat all that was said during a therapy session but must document a patient contact and be sufficiently detailed to allow for both peer review and audits to substantiate the quality and quantity of care rendered.

Prosthetic Device (Prosthesis). An artificial substitute for a missing body part.

Provider. A hospital or other institutional provider, a physician, or other individual professional provider, or other provider of services or supplies as specified in Chapter 6 of this Regulation.

Provider Exclusion and Suspension. The terms "exclusion" and "suspension", when referring to a provider under CHAMPUS, both mean the denial of status as an authorized provider, resulting in items, services, or supplies furnished by the provider not being reimbursed, directly or indirectly, under CHAMPUS. The terms may be used interchangeably to refer to a provider who has been denied status as an authorized CHAMPUS provider based on 1) a criminal conviction or civil judgment involving fraud, 2) an administrative finding of fraud or abuse under CHAMPUS, 3) an administrative finding that the provider has been excluded or suspended by another agency of the Federal Government, a state, or a local licensing authority, 4) an administrative finding that the provider has knowingly participated in a conflict of interest situation, or 5) an administrative finding that it is in the best interests of the CHAMPUS or CHAMPUS beneficiaries to exclude or suspend the provider.

Provider Termination. When a provider's status as an authorized CHAMPUS provider is ended, other than through exclusion or suspension, based on a finding that the provider does not meet the qualifications, as set forth in Chapter 6 of this Regulation, to be an authorized CHAMPUS provider.

Psychiatric Emergency. A psychiatric inpatient admission is an emergency when, based on a psychiatric evaluation performed by a physician (or other qualified mental health care professional with hospital admission authority), the patient is at immediate risk of serious harm to self or others as a result of a mental disorder and requires immediate continuous skilled observation at the acute level of care.

Radiation Therapy Services. The treatment of diseases by x-ray, radium, or radioactive isotopes when ordered by the attending physician.

Referral. The act or an instance of referring a CHAMPUS beneficiary to another authorized provider to obtain necessary medical treatment. Under CHAMPUS, only a physician may make referrals.

Registered Nurse. A person who is prepared specially in the scientific basis of nursing, who is a graduate of a school of nursing, and who is registered for practice after examination by a state board of nurse examiners or similar regulatory authority, who holds a current, valid license, and who is entitled legally to use the designation R.N.

Representative. Any person who has been appointed by a party to the initial determination as counsel or advisor and who is otherwise eligible to serve as the counsel or advisor of the party to the initial determination, particularly in connection with a hearing.

Resident (Medical). A graduate physician or dentist who has an M.D. or D.O. degree, or D.D.S. or D.M.D. degree, respectively, is licensed to practice, and who chooses to remain on the house staff of a hospital to get further training that will qualify him or her for a medical or dental specialty.

Residential Treatment Center (RTC). A facility (or distinct part of a facility) which meets the criteria in Chapter 6.B.4.

Respite care. Respite care is short-term care for a patient in order to provide rest and change for those who have been caring for the patient at home, usually the patient's family.

Retiree. A member or former member of a Uniformed Service who is entitled to retired, retainer, or equivalent pay based on duty in a Uniformed Service.

Routine Eye Examinations. The services rendered in order to determine the refractive state of the eyes.

Sanction. For purpose of Chapter 9, "sanction" means a provider exclusion, suspension, or termination.

Secondary Payer. The plan or program whose medical benefits are payable in double coverage situations only after the primary payer has adjudicated the claim.

Semiprivate Room. A room containing at least two beds. If a room is designated publicly as a semiprivate accommodation by the hospital or other authorized institutional provider and contains multiple beds, it qualifies as a semiprivate room for the purposes of CHAMPUS.

Skilled Nursing Facility. An institution (or a distinct part of an institution) that meets the criteria as set forth in subsection B.4. of Chapter 6 of this Regulation.

Skilled Nursing Service. A service that can only be furnished by an R.N., or L.P.N. or L.V.N., and is required to be performed under the supervision of a physician to ensure the safety of the patient and achieve the medically desired result. Examples of skilled nursing services are intravenous or intramuscular injections, levin tube or gastrostomy feedings, or tracheotomy aspiration and insertion. Skilled nursing services are other than those services that provide primarily support for the essentials of daily living or that could be performed by an untrained adult with minimum instruction or supervision.

Specialized Treatment Service Facility. A military or civilian medical treatment facility specifically designated pursuant to Chapter 4, paragraph A.10, to be a referral facility for certain highly specialized care. For this purpose,a civilian medical treatment facility may be another federal facility (such as a Department of Veterans Affairs hospital).

Special Tutoring. Teaching or instruction provided by a private teacher to an individual usually in a private or separate setting to enhance the educational development of an individual in one or more study areas.

Spectacles, Eyeglasses, and Lenses. Lenses, including contact lenses, that help to correct faulty vision.

Sponsor. An active duty member, retiree, or deceased active duty member or retiree, of a Uniformed Service upon whose status his or her dependents' eligibility for CHAMPUS is based.

Spouse. A lawful wife or husband regardless of whether or not dependent upon the active duty member or retiree.

Student Status. A dependent of a member or former member of a Uniformed Service who has not passed his or her 23rd birthday, and is enrolled in a full-time course of study in an institution of higher learning.

Suppliers of Portable X-Ray Services. A supplier that meets the conditions of coverage of the Medicare program, set forth in the Medicare regulations (reference (m)), or the Medicaid program in the state in which the covered service is provided.

Surgery. Medically appropriate operative procedures, including related preoperative and postoperative care; reduction of fractures and dislocations; injection and needling procedures of the joints; laser surgery of the eye; and those certain procedures listed in paragraph C.2.a. of Chapter 4 of this Regulation.

Surgical Assistant. A physician (or dentist or podiatrist) who assists the operating surgeon in the performance of a covered surgical service when such assistance is certified as necessary by the attending surgeon, when the type of surgical procedure being performed is of such complexity and seriousness as to require a surgical assistant, and when interns, residents, or other house staff are not available to provide the surgical assistance services in the specialty area required.

Suspension of Claims Processing. The temporary suspension of processing (to protect the government's interests) of claims for care furnished by a specific provider (whether the claims are submitted by the provider or beneficiary) or claims submitted by or on behalf of a specific CHAMPUS beneficiary pending action by the Director, OCHAMPUS, or a designee, in a case of suspected fraud or abuse. The action may include the administrative remedies provided for in Chapter 9 or any other Department of Defense issuance (e.g. DoD issuances implementing the Program Fraud Civil Remedies Act), case development or investigation by OCHAMPUS, or referral to the Department of Defense-Inspector General or the Department of Justice for action within their cognizant jurisdictions.

Teaching Physician. A teaching physician is any physician whose duties include providing medical training to physicians in training within a hospital or other institutional provider setting.

Timely Filing. The filing of CHAMPUS claims within the prescribed time limits as set forth in Chapter 7 of this Regulation.

Treatment Plan. A detailed description of the medical care being rendered or expected to be rendered a CHAMPUS beneficiary seeking approval for inpatient benefits for which preauthorization is required as set forth in section B. of Chapter 4 of this Regulation. A treatment plan must include, at a minimum, a diagnosis (either ICD-9-CM or DSM-III); detailed reports of prior treatment, medical history, family history, social history, and physical examination; diagnostic test results; consultant's reports (if any); proposed treatment by type (such as surgical, medical, and psychiatric); a description of who is or will be providing treatment (by discipline or specialty); anticipated frequency, medications, and specific goals of treatment; type of inpatient facility required and why (including length of time the related inpatient stay will be required); and prognosis. If the treatment plan involves the transfer of a CHAMPUS patient from a hospital or another inpatient facility, medical records related to that inpatient stay also are required as a part of the treatment plan documentation.

Uniformed Services. The Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the USPHS, and the Commissioned Corps of the NOAA.

Veteran. A person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.

NOTE: Unless the veteran is eligible for "retired pay," "retirement pay," or "retainer pay," which refers to payments of a continuing nature and are payable at fixed intervals from the government for military service neither the veteran nor his or her dependents are eligible for benefits under CHAMPUS.

Well-Baby Care. A specific program of periodic health screening, developmental assessment, and routine immunization for children from birth up to 2 years.

Widow or Widower. A person who was a spouse at the time of death of the active duty member or retiree and who has not remarried.

Worker's Compensation Benefits. Medical benefits available under any worker's compensation law (including the Federal Employees Compensation Act), occupational disease law, employers liability law, or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure.

X-Ray Services. An x-ray examination from which an x-ray film or other image is produced, ordered by the attending physician when necessary and rendered in connection with a medical or surgical diagnosis or treatment of an illness or injury, or in connection with maternity or well-baby care.

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on the same basis as the related maternity care for a period not to exceed 42 days following termination of the pregnancy and thereafter cost-shared on the basis of the inpatient or outpatient status of the beneficiary when medically necessary services and supplies are received.

17. Biofeedback Therapy. Biofeedback therapy is a technique by which a person is taught to exercise control over a physiologic process occurring within the body. By using modern biomedical instruments the patient learns how a specific physiologic system within his body operates and how to modify the performance of this particular system.

a. Benefits provided. CHAMPUS benefits are payable for services and supplies in connection with electrothermal, electromyograph and electrodermal biofeedback therapy when there is documentation that the patient has undergone an appropriate medical evaluation, that their present condition is not responding to or no longer responds to other forms of conventional treatment, and only when provided as treatment for the following conditions:

(1) Adjunctive treatment for Raynaud's Syndrome.

(2) Adjunctive treatment for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, or incapacitating muscle spasm or weakness.

b. Limitations. Payable benefits include initial intake evaluation. Treatment following the initial intake evaluation is limited to a maximum of 20 inpatient and outpatient biofeedback treatments per calendar year.

c. Exclusions. Benefits are excluded for biofeedback therapy for the treatment of ordinary muscle tension states or for psychosomatic conditions. Benefits are also excluded for the rental or purchase of biofeedback equipment.

d. Provider requirements. A provider of biofeedback therapy must be a CHAMPUS-authorized provider. (Refer to CHAPTER 6, "Authorized Providers.") If biofeedback treatment is provided by other than a physician, the patient must be referred by a physician.

e. Implementation Guidelines. The Director, OCHAMPUS, shall issue guidelines as are necessary to implement the provisions of this paragraph.

18. Cardiac Rehabilitation. Cardiac rehabilitation is the process by which individuals are restored to their optimal physical, medical and psychological status, after a cardiac event. Cardiac rehabilitation is often divided into three phases. Phase I begins during inpatient hospitalization and is managed by the patient's personal physician. Phase II is a medically supervised outpatient program which begins following discharge. Phase III is a lifetime maintenance program emphasizing continuation of physical fitness with periodic followup. Each phase includes an exercise component, patient education, and risk factor modification. There may be considerable variation in program components, intensity and duration.

a. Benefits Provided. CHAMPUS benefits are available on an inpatient or outpatient basis for services and supplies provided in connection with a cardiac rehabilitation program when ordered by a physician and provided as treatment for patients who have experienced the following cardiac events within the preceding twelve (12) months:

(1) Myocardial Infarction.

(2) Coronary Artery Bypass Graft.

(3) Coronary Angioplasty.

(4) Percutaneous Transluminal Coronary Angioplasty.

(5) Chronic Stable Angina (see limitations below).

b. Limitations. Payable benefits include separate allowance for the initial evaluation and testing. Outpatient treatment following the initial intake evaluation and testing is limited to a maximum of thirty-six (36) sessions per cardiac event, usually provided 3 sessions per week for twelve weeks. Patient's diagnosed with chronic stable angina are limited to one treatment episode (36 sessions) in a calendar year.

c. Exclusions. Phase III cardiac rehabilitation lifetime maintenance programs performed at home or in medically unsupervised settings are not covered.

d. Providers. A provider of cardiac rehabilitation services must be a CHAMPUS authorized hospital. (Refer to Chapter 6, "Authorized Providers.") All cardiac rehabilitation services must be ordered by a physician.

e. Payment. Payment for outpatient treatment will be based on an all inclusive allowable charge per session. Inpatient treatment will be paid based upon the reimbursement system in place for the hospital where the services are rendered.

f. Implementation Guidelines: The Director of OCHAMPUS shall issue guidelines as are necessary to implement the provisions of this paragraph.

19. Hospice care. Hospice care is a program which provides an integrated set of services and supplies designed to care for the terminally ill. This type of care emphasizes palliative care and supportive services, such as pain control and home care, rather than cure-oriented services provided in institutions that are otherwise the primary focus under CHAMPUS. The benefit provides coverage for a humane and sensible approach to care during the last days of life for some terminally ill patients.

a. Benefit coverage. CHAMPUS beneficiaries who are terminally ill (that is, a life expectancy of six months or less if the disease runs its normal course) will be eligible for the following services and supplies in lieu of most other CHAMPUS benefits:

(1) Physician services.

(2) Nursing care provided by or under the supervision of a registered professional nurse.

(3) Medical social services provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician. Medical social services include, but are not limited to the following:

(a) Assessment of social and emotional factors related to the beneficiary's illness, need for care, response to treatment, and adjustment to care.

(b) Assessment of the relationship of the beneficiary's medical and nursing requirements to the individual's home situation, financial resources, and availability of community resources.

(c) Appropriate action to obtain available community resources to assist in resolving the beneficiary's problem.

(d) Counseling services that are required by the beneficiary.

(4) Counseling services provided to the terminally ill individual and the family member or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other care-giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death. Bereavement counseling, which consists of counseling services provided to the individual's family after the individual's death, is a required hospice service but it is not reimbursable.

(5) Home health aide services furnished by qualified aides and homemaker services. Home health aides may provide personal care services. Aides also may perform household services to maintain a safe and sanitary environment in areas of the home used by the patient. Examples of such services are changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment, and services to enable the individual to carry out the plan of care. Qualifications for home health aides can be found in 42 C.F.R. section 484.36.

(6) Medical appliances and supplies, including drugs and biologicals. Only drugs that are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. Appliances may include covered durable medical equipment, as well as other self-help and personal comfort items related to the palliation or management of the patient's condition while he or she is under hospice care. Equipment is provided by the hospice for use in the beneficiary's home while he or she is under hospice care. Medical supplies include those that are part of the written plan of care. Medical appliances and supplies are included within the hospice all-inclusive rates.

(7) Physical therapy, occupational therapy and speech-language pathology services provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

(8) Short-term inpatient care provided in a Medicare participating hospice inpatient unit, or a Medicare participating hospital, skilled nursing facility (SNF) or, in the case of respite care, a Medicaid-certified nursing facility that additionally meets the special hospice standards regarding staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. Inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home. Respite care is the only type of inpatient care that may be provided in a Medicaid-certified nursing facility. The limitations on custodial care and personal comfort items applicable to other CHAMPUS services are not applicable to hospice care.

b. Core services. The hospice must ensure that substantially all core services are routinely provided directly by hospice employees; i.e., physician services, nursing care, medical social services, and counseling for individuals and care givers. Refer to paragraphs E.19.a.(1), E.19.a.(2), E.19.a.(3), and E.19.a.(4) of this chapter.

c. Non-core services. While non-core services (i.e., home health aide services, medical appliances and supplies, drugs and biologicals, physical therapy, occupational therapy, speech-language pathology and short-term inpatient care) may be provided under arrangements with other agencies or organizations, the hospice must maintain professional management of the patient at all times and in all settings. Refer to paragraphs E.19.a.(5), E.19.a.(6), E.19.a.(7), and E.19.a.(8) of this chapter.

d. Availability of services. The hospice must make nursing services, physician services, and drugs and biologicals routinely available on a 24-hour basis. All other covered services must be made available on a

24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of the terminal illness and related condition. These services must be provided in a manner consistent with accepted standards of practice.

e. Periods of care. Hospice care is divided into distinct periods/episodes of care. The terminally ill beneficiary may elect to receive hospice benefits for an initial period of 90 days, a subsequent period of 90 days, a second subsequent period of 30 days, and a final period of unlimited duration.

f. Conditions for coverage. The CHAMPUS beneficiary must meet the following conditions/criteria in order to be eligible for the hospice benefits and services referenced in paragraph E.19.a. of this chapter.

(1) There must be written certification in the medical record that the CHAMPUS beneficiary is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

(a) Timing of certification. The hospice must obtain written certification of terminal illness for each of the election periods described in paragraph E.19.f.(2) of this chapter, even if a single election continues in effect for two, three or four periods.

1 Basic requirement. Except as provided in paragraph E.19.f.(1)(a)2 of this chapter, the hospice must obtain the written certification no later than two calendar days after the period begins.

2 Exception. For the initial 90-day period, if the hospice cannot obtain the written certifications within two calendar days, it must obtain oral certifications within two calendar days, and written certifications no later than eight calendar days after the period begins.

(b) Sources of certification. Physician certification is required for both initial and subsequent election periods.

1 For the initial 90-day period, the hospice must obtain written certification statements (and oral certification statements if required under paragraph E.19.f.(1)(a)2 of this chapter) from:

a The individual's attending physician if the individual has an attending physician; and

b The medical director of the hospice or the physician member of the hospice interdisciplinary group.

2 For subsequent periods, the only requirement is certification by one of the physicians listed in paragraph E.19.f.(1)(b)1 b of this section.

(2) The terminally ill beneficiary must elect to receive hospice care for each specified period of time; i.e., the two 90-day periods, a subsequent 30-day period, and a final period of unlimited duration. If the individual is found to be mentally incompetent, his or her representative may file the election statement. Representative means an individual who has been authorized under State law to terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill individual who is found to be mentally incompetent.

(a) The episodes of care must be used consecutively; i.e., the two 90-day periods first, then the 30-day period, followed by the final period. The periods of care may be elected separately at different times.

(b) The initial election will continue through subsequent election periods without a break in care as long as the individual remains in the care of the hospice and does not revoke the election.

(c) The effective date of the election may begin on the first day of hospice care or any subsequent day of care, but the effective date cannot be made prior to the date that the election was made.

(d) The beneficiary or representative may revoke a hospice election at any time, but in doing so, the remaining days of that particular election period are forfeited and standard CHAMPUS coverage resumes. To revoke the hospice benefit, the beneficiary or representative must file a signed statement of revocation with the hospice. The statement must provide the date that the revocation is to be effective. An individual or representative may not designate an effective date earlier than the date that the revocation is made.

(e) If an election of hospice benefits has been revoked, the individual, or his or her representative may at any time file a hospice election for any period of time still available to the individual, in accordance with Chapter 4.E.19.f.(2).

(f) A CHAMPUS beneficiary may change, once in each election period, the designation of the particular hospice from which he or she elects to receive hospice care. To change the designation of hospice programs the individual or representative must file, with the hospice from which care has been received and with the newly designated hospice, a statement that includes the following information:

1 The name of the hospice from which the individual has received care and the name of the hospice from which he or she plans to receive care.

2 The date the change is to be effective.

(g) Each hospice will design and print its own election statement to include the following information:

1 Identification of the particular hospice that will provide care to the individual.

2 The individual's or representative's acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual's terminal illness.

3 The individual's or representative's acknowledgment that he or she understands that certain other CHAMPUS services are waived by the election.

4 The effective date of the election.

5 The signature of the individual or representative, and the date signed.

(h) The hospice must notify the CHAMPUS contractor of the initiation, change or revocation of any election.

(3) The beneficiary must waive all rights to other CHAMPUS payments for the duration of the election period for:

(a) Care provided by any hospice program other than the elected hospice unless provided under arrangements made by the elected hospice; and

(b) Other CHAMPUS basic program services/benefits related to the treatment of the terminal illness for which hospice care was elected, or to a related condition, or that are equivalent to hospice care, except for services provided by:

1 the designated hospice;

2 another hospice under arrangements made by the designated hospice; or

3 an attending physician who is not employed by or under contract with the hospice program.

(c) Basic CHAMPUS coverage will be reinstated upon revocation of the hospice election.

(4) A written plan of care must be established by a member of the basic interdisciplinary group assessing the patient's needs. This group must have at least one physician, one registered professional nurse, one social worker, and one pastoral or other counselor.

(a) In establishing the initial plan of care the member of the basic interdisciplinary group who assesses the patient's needs must meet or call at least one other group member before writing the initial plan of care.

(b) At least one of the persons involved in developing the initial plan must be a nurse or physician.

(c) The plan must be established on the same day as the assessment if the day of assessment is to be a covered day of hospice care.

(d) The other two members of the basic interdisciplinary group -- the attending physician and the medical director or physician designee -- must review the initial plan of care and provide their input to the process of establishing the plan of care within two calendar days following the day of assessment. A meeting of group members is not required within this 2-day period. Input may be provided by telephone.

(e) Hospice services must be consistent with the plan of care for coverage to be extended.

(f) The plan must be reviewed and updated, at intervals specified in the plan, by the attending physician, medical director or physician designee and interdisciplinary group. These reviews must be documented in the medical records.

(g) The hospice must designate a registered nurse to coordinate the implementation of the plan of care for each patient.

(h) The plan must include an assessment of the individual's needs and identification of the services, including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

(5) Complete medical records and all supporting documentation must be submitted to the CHAMPUS contractor within 30 days of the date of its request. If records are not received within the designated time frame, authorization of the hospice benefit will be denied and any prior payments made will be recouped. A denial issued for this reason is not an initial determination under Chapter 10, and is not appealable.

g. Appeal rights under hospice benefit. A beneficiary or provider is entitled to appeal rights for cases involving a denial of benefits in accordance with the provisions of this Chapter and Chapter 10.

F. BENEFICIARY OR SPONSOR LIABILITY

1. General. As stated in the introductory paragraph to this chapter, the Basic Program is essentially a supplemental program to the Uniformed

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Services direct medical care system. To encourage use of the Uniformed Services direct medical care system wherever its facilities are available and appropriate, the Basic Program benefits are designed so that it is to the financial advantage of a CHAMPUS beneficiary or sponsor to use the direct medical care system. When medical care is received from civilian sources, a CHAMPUS beneficiary is responsible for payment of certain deductible and cost-sharing amounts in connection with otherwise covered services and supplies. By statute, this joint financial responsibility between the beneficiary or sponsor and CHAMPUS is more favorable for dependents of active duty members than for other classes of beneficiaries.

2. Dependents of active duty members of the Uniformed Services. CHAMPUS beneficiary or sponsor liability set forth for dependents of active duty members is as follows:

a. Annual fiscal year deductible for outpatient services and supplies.

(1) For care rendered all eligible beneficiaries prior to April 1, 1991, or when the active duty sponsor's pay grade is E-4 or below, regardless of the date of care:

(a) **Individual Deductible:** Each beneficiary is liable for the first fifty dollars ($50.00) of the CHAMPUS-determined allowable amount on claims for care provided in the same fiscal year.

(b) **Family Deductible:** The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed one hundred dollars ($100.00).

(2) For care rendered on or after April 1, 1991, for all CHAMPUS beneficiaries except dependents of active duty sponsors of pay grades E-4 or below:

(a) **Individual Deductible:** Each beneficiary is liable for the first one hundred and fifty dollars ($150.00) of the CHAMPUS-determined allowable amount on claims for care provided in the same fiscal year.

(b) **Family Deductible:** The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed three hundred dollars ($300.00).

(3) CHAMPUS-Approved Ambulatory Surgical Centers or Birthing Centers. No deductible shall be applied to allowable amounts for services or items rendered to active duty or authorized NATO dependents.

(4) Allowable Amount does not exceed Deductible Amount. If fiscal year allowable amounts for two or more beneficiary members of a family total less than $100.00 ($300.00 if 2.a.(2)(b) above applies), but

none of the beneficiary members submit a claim for over $50.00 ($150.00 if 2.a.(2)(a) above applies), neither the family nor the individual deductible will have been met and no CHAMPUS benefits are payable.

(5) For any family the outpatient deductible amounts will be applied sequentially as the CHAMPUS claims are processed.

(6) If the fiscal year outpatient deductible under either F.2.a.(1) or F.2.a.(2) above has been met by a beneficiary or a family through the submission of a claim or claims to a CHAMPUS fiscal intermediary in another geographic location from the location where a current claim is being submitted, the beneficiary or sponsor must obtain a deductible certificate from the CHAMPUS fiscal intermediary where the applicable beneficiary or family fiscal year deductible was met. Such deductible certificate must be attached to the current claim being submitted for benefits. Failure to obtain a deductible certificate under such circumstances will result in a second beneficiary or family fiscal year deductible being applied. However, this second deductible may be reimbursed once appropriate documentation, as described in this subparagraph F.2.a.(6), is supplied to the CHAMPUS fiscal intermediary applying the second deductible (refer to section A. of Chapter 7 of this Regulation).

(7) Notwithstanding the dates specified in paragraphs F.2.a.(1) and (2), in the case of the dependents of active duty members of rank E-5 or above with Persian Gulf conflict service, the deductible shall be the amount specified in paragraph (1) for care rendered prior to October 1, 1991, and the amount specific in paragraph (2) for care rendered after October 1, 1991. For purposes of the preceding sentence, a member with Persian Gulf conflict service is a member who is, or was entitled to special pay for hostile fire/imminent danger authorized by 37 U.S.C. 310, for services in the Persian Gulf area in connection with Operation Desert Shield or Operation Desert Storm.

b. Inpatient cost-sharing. Dependents of active duty members of the Uniformed Services or their sponsors are responsible for the payment of the first $25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider (refer to Chapter 6 of this Regulation), or the amount the beneficiary or sponsor would have been charged had the inpatient care been provided in a Uniformed Service hospital, whichever is greater.

NOTE: The Secretary of Defense (after consulting with the Secretary of Health and Human Services and the Secretary of Transportation) prescribes the fair charges for inpatient hospital care provided through Uniformed Services medical facilities. This determination is made each fiscal year.

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(1) Inpatient cost-sharing payable with each separate inpatient admission. A separate cost-sharing amount (as described in this subsection F.2.) is payable for each inpatient admission to a hospital or other authorized institution, regardless of the purpose of the admission (such as medical or surgical), regardless of the number of times the beneficiary is admitted, and regardless of whether or not the inpatient admissions are for the same or related conditions; except that successive inpatient admissions shall be deemed one inpatient confinement for the purpose of computing the inpatient cost-share payable, provided not more than 60 days have elapsed between the successive admissions. However, notwithstanding this provision, all admissions related to a single maternity episode shall be considered one confinement, regardless of the number of days between admissions (refer to section B. of this chapter).

(2) Multiple family inpatient admissions. A separate cost-sharing amount is payable for each inpatient admission, regardless of whether or not two or more beneficiary members of a family are admitted at the sametime or from the same cause (such as an accident). A separate beneficiary inpatient cost-sharing amount must be applied for each separate admission on each beneficiary member of the family.

(3) Newborn patient in his or her own right. When a newborn infant remains as an inpatient in his or her own right (usually after the mother is discharged), the newborn child becomes the beneficiary and patient and the extended inpatient stay becomes a separate inpatient admission. In such a situation, a new, separate inpatient cost-sharing amount is applied. If a multiple birth is involved (such as twins or triplets) and two or more newborn infants become patients in their own right, a separate inpatient cost-sharing amount must be applied to the inpatient stay for each newborn child who has remained as an inpatient in his or her own right.

c. Outpatient cost-sharing. Dependents of active duty members of the Uniformed Services or their sponsors are responsible for payment of 20 percent of the CHAMPUS-determined allowable cost or charge beyond the annual fiscal year deductible amount (as described in paragraph F.2.a. of this chapter) for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

d. Ambulatory surgery. Notwithstanding the above provisions pertaining to outpatient cost-sharing, dependents of active duty members of the Uniformed Services or their sponsors are responsible for payment of $25 for surgical care that is authorized and received while in an outpatient status and that has been designated in guidelines issued by the Director, OCHAMPUS, or a designee.

e. Psychiatric partial hospitalization services. Institutional and professional services provided under the psychiatric partial hospitalization program authorized by paragraph B.10. of this chapter shall be cost-shared as inpatient services.

3. Retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees. CHAMPUS beneficiary liability set forth for retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees is as follows:

a. Annual fiscal year deductible for outpatient services or supplies. The annual fiscal year deductible for otherwise covered outpatient services or supplies provided retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees, is the same as the annual fiscal year outpatient deductible applicable to dependents of active duty members of rank E-5 or above (refer to paragraph F.2.a.(1) or (2) of this chapter).

b. Inpatient cost-sharing. Cost-sharing amounts for inpatient services shall be as follows:

(1) Services subject to the CHAMPUS DRG-based payment system. The cost-share shall be the lesser of an amount calculated by multiplying a per diem amount for each day of the hospital stay except the day of discharge or 25 percent of the hospital's billed charges. The per diem amount shall be calculated so that total cost-sharing amounts for these beneficiaries is equivalent to 25 percent of the CHAMPUS-determined allowable costs for covered services or supplies provided on an inpatient basis by authorized providers. The per diem amount shall be published annually by CHAMPUS.

(2) Services subject to the mental health per diem payment system. The cost-share is dependent upon whether the hospital is paid a hospital-specific per diem or a regional per diem under the provisions of subsection A.2. of Chapter 14. With respect to care paid for on the basis of a hospital-specific per diem, the cost-share shall be 25% of the hospital-specific per diem amount. For care paid for on the basis of a regional per diem, the cost share shall be the lower of a fixed daily amount or 25% of the hospital's billed charges. The fixed daily amount shall be 25% of the per diem adjusted so that total beneficiary cost-shares will equal 25% of total payments under the mental health per diem payment system. This fixed daily amount shall be updated annually and published in the Federal Register along with the per diems published pursuant to subparagraph A.2.d.(2) of Chapter 14.

(3) Other services. For services exempt from the CHAMPUS DRG-based payment system and the CHAMPUS mental health per diem payment system and services provided by institutions other than hospitals, the cost-share shall be 25% of the CHAMPUS-determined allowable charges.

c. Outpatient cost-sharing.

(1) For services other than ambulatory surgery services. Retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees are responsible for payment of 25 percent of the CHAMPUS-determined allowable costs or charges beyond the annual fiscal

year deductible amount (as described in paragraph F.2.a. of this chapter) for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

(2) For services subject to the ambulatory surgery payment method. For services subject to the ambulatory surgery payment method set forth in Chapter 14 D., of this regulation, the cost share shall be the lesser of: 25 percent of the payment amount provided pursuant to Chapter 14.D.; or 25 percent of the center's billed charges.

d. Psychiatric partial hospitalization services. Institutional and professional services provided under the psychiatric partial hospitalization program authorized by paragraph B.10. of this chapter shall be cost-shared as inpatient services.

4. Former spouses. CHAMPUS beneficiary liability set forth for former spouses eligible under the provisions of paragraph B.2.b. of Chapter 3 is as follows:

a. Annual fiscal year deductible for outpatient services or supplies. An eligible former spouse is responsible for the payment of the first $150 of the CHAMPUS-determined reasonable costs or charges for otherwise covered outpatient services or supplies provided in any one fiscal year. (Except for services re- ceived prior to April 1, 1991, the deductible amount is $50.00). The former spouse cannot contribute to, nor benefit from, any family deductible of the member or former member to whom the former spouse was married or of any CHAMPUS-eligible children.

b. Inpatient cost-sharing. Eligible former spouses are responsible for the payment of cost-sharing amounts the same as those required for retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees.

c. Outpatient cost-sharing. Eligible former spouses are responsible for payment of 25 percent of the CHAMPUS-determined reasonable costs or charges beyond the annual fiscal year deductible amount for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

5. Cost-Sharing under the Military-Civilian Health Services Partnership Program. Cost-sharing is dependent upon the type of partnership program entered into, whether external or internal. (See section P. of Chapter 1, for general requirements of the Military-Civilian Health Services Partnership Program.)

a. External Partnership Agreement. Authorized costs associated with the use of the civilian facility will be financed through CHAMPUS under the normal cost-sharing and reimbursement procedures applicable under CHAMPUS.

b. Internal Partnership Agreement. Beneficiary cost-share under internal agreements will be the same as charges prescribed for care in military treatment facilities.

6. Amounts over CHAMPUS-determined allowable costs or charges. It is the responsibility of the CHAMPUS fiscal intermediary to determine allowable costs for services and supplies provided by hospitals and other institutions and allowable charges for services and supplies provided by physicians, other individual professional providers, and other providers. Such CHAMPUS-determined allowable costs or charges are made in accordance with the provisions of Chapter 14. All CHAMPUS benefits, including calculation of the CHAMPUS or beneficiary cost-sharing amounts, are based on such CHAMPUS-determined allowable costs or charges. The effect on the beneficiary when the billed cost or charge is over the CHAMPUS-determined allowable amount is dependent upon whether or not the applicable claim was submitted on a participating basis on behalf of the beneficiary or submitted directly by the beneficiary on a nonparticipating basis and on whether the claim is for inpatient hospital services subject to the CHAMPUS DRG-based payment system. This provision applies to all classes of CHAMPUS beneficiaries.

NOTE: When the provider "forgives" or "waives" any beneficiary liability, such as amounts applicable to the annual fiscal year deductible for outpatient services or supplies, or the inpatient or outpatient cost-sharing as previously set forth in this section, the CHAMPUS-determined allowable charge or cost allowance (whether payable to the CHAMPUS beneficiary or sponsor, or to a participating provider) shall be reduced by the same amount.

a. Participating providers. There are several circumstances under which institutional and individual providers may be Participating Providers, either on a mandatory basis or a voluntary basis. See Chapter 6, A.8. A Participating Provider, whether participating for all claims or on a claim-by-claim basis, must accept the CHAMPUS-determined allowable amount as payment in full for the medical services or supplies provided, and must accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-sharing and deductible amounts paid by or on behalf of the beneficiary as payment in full for the covered medical services or supplies. Therefore, when costs or charges are submitted on a participating basis, the patient is not obligated to pay any amounts disallowed as being over the CHAMPUS-determined allowable cost or charge for authorized services or supplies.

b. Nonparticipating providers. Nonparticipating providers are those providers who do not agree on the CHAMPUS claim form to participate and thereby do not agree to accept the CHAMPUS-determined allowable costs or charges as the full charge. For otherwise covered services and supplies provided by such nonparticipating CHAMPUS providers, payment is made directly to the beneficiary or sponsor and the beneficiary is liable under applicable law for any amounts over the CHAMPUS-determined allowable costs or charges. CHAMPUS shall have no responsibility for any amounts over allowable costs or charges as determined by CHAMPUS.

7. [Reserved]

8. Cost-sharing for services provided under special discount arrangements.

a. General rule. With respect to services determined by the Director, OCHAMPUS (or designee) to be covered by Chapter 14, section I., the Director, OCHAMPUS (or designee) has authority to establish, as an exception to the cost-sharing amount normally required pursuant to this chapter, a different cost-share amount that appropriately reflects the application of the statutory cost-share to the discount arrangement.

b. Specific applications. The following are examples of applications of the general rule; they are not all inclusive.

(1) In the case of services provided by individual health care professionals and other noninstitutional providers, the cost-share shall be the usual percentage of the CHAMPUS allowable charge determined under Chapter 14, section I.

(2) In the case of services provided by institutional providers normally paid on the basis of a pre-set amount (such as DRG-based amount under Chapter 14, section A.1. or per-diem amount under Chapter 14, section A.2.), if the discount rate is lower than the pre-set rate, the cost-share amount that would apply for a beneficiary other than an active duty dependent pursuant to the normal pre-set rate would be reduced by the same percentage by which the pre-set rate was reduced in setting the discount rate.

9. Waiver of deductible amounts or cost-sharing not allowed.

a. General rule. Because deductible amounts and cost sharing are statutorily mandated, except when specifically authorized by law (as determined by the Director, OCHAMPUS), a provider may not waive or forgive beneficiary liability for annual deductible amounts or inpatient or outpatient cost-sharing, as set forth in this chapter.

b. Exception for bad debts. This general rule is not violated in cases in which a provider has made all reasonable attempts to effect collection, without success, and determines in accordance with generally accepted fiscal management standards that the beneficiary liability in a particular case is an uncollectible bad debt.

c. Remedies for noncompliance. Potential remedies for noncompliance with this requirement include:

(1) A claim for services regarding which the provider has waived the beneficiary's liability may be disallowed in full, or, alternatively, the amount payable for such a claim may be reduced by the amount of the beneficiary liability waived.

(2) Repeated noncompliance with this requirement is a basis for exclusion of a provider.

G. EXCLUSIONS AND LIMITATIONS

In addition to any definitions, requirements, conditions, or limitations enumerated and described in other chapters of this Regulation, the following specifically are excluded from the Basic Program:

1. Not medically or psychologically necessary. Services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of a covered illness (including mental disorder) or injury, for the diagnosis and treatment of pregnancy, or for well-baby care except as provided in the following paragraph.

2. Unnecessary diagnostic tests. X-ray, laboratory, and pathological services and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms except for cancer screening mammography and cancer screening papanicolaou (PAP) smears provided under the terms and conditions contained in the guidelines adopted by the Director, OCHAMPUS.

3. Institutional level of care. Services and supplies related to in-patient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care.

4. Diagnostic admission. Services and supplies related to an inpatient admission primarily to perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis.

NOTE: If it is determined that the diagnostic x-ray, laboratory, and pathological services and machine tests performed during such admission were medically necessary and would have been covered if performed on an outpatient basis, CHAMPUS benefits may be extended for such diagnostic procedures only, but cost-sharing will be computed as if performed on an outpatient basis.

5. Unnecessary postpartum inpatient stay, mother or newborn. Postpartum inpatient stay of a mother for purposes of staying with the newborn infant (usually primarily for the purpose of breast feeding the infant) when the infant (but not the mother) requires the extended stay; or continued inpatient stay of a newborn infant primarily for purposes of remaining with the mother when the mother (but not the newborn infant) requires extended postpartum inpatient stay.

6. Therapeutic absences. Therapeutic absences from an inpatient facility, except when such absences are specifically included in a treatment plan approved by the Director, OCHAMPUS, or a designee. For cost-sharing provisions refer to Chapter 14, paragraph F.3.

7. Custodial care. Custodial care regardless of where rendered, except as otherwise specifically provided in paragraphs E.12.b., E.12.c. and E.12.d. of this chapter.

8. Domiciliary care. Inpatient stays primarily for domiciliary care purposes.

9. Rest or rest cures. Inpatient stays primarily for rest or rest cures.

10. Amounts above allowable costs or charges. Costs of services and supplies to the extent amounts billed are over the CHAMPUS determined allowable cost or charge, as provided for in Chapter 14.

11. No legal obligation to pay, no charge would be made. Services or supplies for which the beneficiary or sponsor has no legal obligation to pay; or for which no charge would be made if the beneficiary or sponsor was not eligible under CHAMPUS; or whenever CHAMPUS is a secondary payer for claims subject to the CHAMPUS DRG-based payment system, amounts, when combined with the primary payment, which would be in excess of charges (or the amount the provider is obligated to accept as payment in full, if it is less than the charges).

12. Furnished without charge. Services or supplies furnished without charge.

13. Furnished by local, state, or Federal Government. Services and supplies paid for, or eligible for payment, directly or indirectly by a local, state, or Federal Government, except as provided under CHAMPUS, or by government hospitals serving the general public, or medical care provided by a Uniformed Service medical care facility, or benefits provided under title XIX of the Social Security Act (Medicaid) (reference (h)) (refer to Chapter 8 of this Regulation).

14. Study, grant, or research programs. Services and supplies provided as a part of or under a scientific or medical study, grant, or research program.

15. Not in accordance with accepted standards, experimental or investigational. Services and supplies not provided in accordance with accepted professional medical standards; or related to essentially experimental or investigational procedures or treatment regimens.

16. Immediate family, household. Services or supplies provided or prescribed by a member of the beneficiary's immediate family, or a person living in the beneficiary's or sponsor's household.

17. Double coverage. Services and supplies that are (or are eligible to be) payable under another medical insurance or program, either private or governmental, such as coverage through employment or Medicare (refer to Chapter 8 of this Regulation).

18. Nonavailability Statement required. Services and supplies provided under circumstances or in geographic locations requiring a Nonavailability Statement (DD Form 1251), when such a statement was not obtained.

19. Preauthorization required. Services or supplies which require preauthorization if preauthorization was not obtained. Services and supplies which were not provided according to the terms of the preauthorization. The Director, OCHAMPUS, or a designee, may grant an exception to the requirement for preauthorization if the services otherwise would be payable except for the failure to obtain preauthorization.

20. Psychoanalysis or psychotherapy, part of education. Psychoanalysis or psychotherapy provided to a beneficiary or any member of the immediate family that is credited towards earning a degree or furtherance of the education or training of a beneficiary or sponsor, regardless of diagnosis or symptoms that may be present.

21. Runaways. Inpatient stays primarily to control or detain a runaway child, whether or not admission is to an authorized institution.

22. Services or supplies ordered by a court or other government agency. Services or supplies, including inpatient stays, directed or agreed to by a court or other governmental agency. However, those services and supplies (including inpatient stays) that otherwise are medically or psychologically necessary for the diagnosis or treatment of a covered condition and that otherwise meet all CHAMPUS requirements for coverage are not excluded.

23. Work-related (occupational) disease or injury. Services and supplies required as a result of occupational disease or injury for which any benefits are payable under a worker's compensation or similar law, whether or not such benefits have been applied for or paid; except if benefits provided under such laws are exhausted.

24. Cosmetic, reconstructive, or plastic surgery. Services and supplies in connection with cosmetic, reconstructive, or plastic surgery except as specifically provided in subsection E.8. of this chapter.

25. Surgery, psychological reasons. Surgery performed primarily for psychological reasons (such as psychogenic).

26. Electrolysis.

27. Dental care. Dental care or oral surgery, except as specifically provided in subsection E.10. of this chapter.

28. Obesity, weight reduction. Services and supplies related to obesity or weight reduction whether surgical or nonsurgical; wiring of the jaw or any procedure of similar purpose, regardless of the circumstances under which performed; except that benefits may be provided for the gastric bypass, gastric stapling, or gastroplasty procedures in connection with morbid obesity as provided in subsection E.15. of this chapter.

29. Transsexualism or such other conditions as gender dysphoria. Services and supplies related to transsexualism or such other conditions as gender dysphoria (including, but not limited, to intersex surgery, psychotherapy, and prescription drugs), except as specifically provided in subsection E.7. of this chapter.

30. Therapy or counseling for sexual dysfunctions or sexual inadequacies.
Sex therapy, sexual advice, sexual counseling, sex behavior modification, psychotherapy for mental disorders involving sex deviations (e.g., transvestic fetishism), or other similar services, and any supplies provided in connection with therapy for sexual dysfunctions or inadequacies.

31. Corns, calluses, and toenails. Removal of corns or calluses or trimming of toenails and other routine podiatry services, except those required as a result of a diagnosed systemic medical disease affecting the lower limbs, such as severe diabetes.

32. Dyslexia.

33. Surgical sterilization, reversal. Surgery to reverse surgical sterilization procedures.

34. Noncoital reproductive procedures including artificial insemination, in-vitro fertilization, gamete intrafallopian transfer and all other such reproductive technologies. Services and supplies related to artificial insemination (including semen donors and semen banks), in-vitro fertilization, gamete intrafallopian transfer and all other noncoital reproductive technologies.

35. Nonprescription contraceptives.

36. Tests to determine paternity or sex of a child. Diagnostic tests to establish paternity of a child; or tests to determine sex of an unborn child.

37. Preventive care. Preventive care, such as routine, annual, or employment requested physical examinations; routine screening procedures; immunizations; except that the following are not excluded:

a. Well-baby care, including newborn examination, Phenylketonuria (PKU) testing and newborn circumcision.

b. Rabies shots.

c. Tetanus shot following an accidental injury.

d. Rh immune globulin.

e. Genetic tests as specified in paragraph E.3.b. of this chapter.

f. Immunizations and physical examinations provided when required in the case of dependents of active duty military personnel who are traveling outside the United States as a result of an active member's duty assignment and such travel is being performed under orders issued by a Uniformed Service.

g. Screening mammography for asymptomatic women 35 years of age and older when provided under the terms and conditions contained in the guidelines adopted by the Director OCHAMPUS.

h. Cancer screening papanicolaou (PAP) smear for women who are or have been sexually active, and women 18 years of age and older under the terms and conditions contained in the guidelines adopted by the Director, OCHAMPUS.

38. Chiropractors and naturopaths. Services of chiropractors and naturopaths whether or not such services would be eligible for benefits if rendered by an authorized provider.

39. Counseling. Counseling services that are not medically necessary in the treatment of a diagnosed medical condition; for example, educational counseling, vocational counseling, nutritional counseling, counseling for socio-economic purposes, diabetic self-education programs, stress management, life style modification, etc. Services provided by a certified marriage and family therapist, pastoral or mental health counselor in the treatment of a mental disorder are covered only as specifically provided in Chapter 6. Services provided by alcoholism rehabilitation counselors and certified addiction counselors are covered only when rendered in a CHAMPUS-authorized treatment setting and only when the cost of those services is included in the facility's CHAMPUS-determined allowable cost-rate.

40. Acupuncture. Acupuncture, whether used as a therapeutic agent or as an anesthetic.

41. Hair transplants, wigs, or hairpieces

NOTE: In accordance with Section 744 of the DoD Appropriation Act for 1981 (reference (o)), CHAMPUS coverage for wigs or hairpieces is permitted effective December 15, 1980, under the conditions listed below. Continued availability of benefits will depend on the language of the annual DoD Appropriation Acts.

a. Benefits provided. Benefits may be extended, in accordance with the CHAMPUS-determined allowable charge, for one wig or hairpiece per beneficiary (lifetime maximum) when the attending physician certifies that alopecia has resulted from treatment of a malignant disease and the beneficiary certifies that a wig or hairpiece has not been obtained previously through the U.S. Government (including the Veterans Administration).

b. Exclusions. The wig or hairpiece benefit does not include coverage for the following:

(1) Alopecia resulting from conditions other than treatment of malignant disease.

(2) Maintenance, wig or hairpiece supplies, or replacement of the wig or hairpiece.

(3) Hair transplants or any other surgical procedure involving the attachment of hair or a wig or hairpiece to the scalp.

(4) Any diagnostic or therapeutic method or supply intended to encourage hair regrowth.

42. Education or training. Self-help, academic education or vocational training services and supplies, unless the provisions of Chapter 4, paragraph B.1.e., relating to general or special education, apply.

43. Exercise/Relaxation/Comfort Devices. Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club membership or other such charges or items.

44. Exercise. General exercise programs, even if recommended by a physician and regardless of whether or not rendered by an authorized provider. In addition, passive exercises and range of motion exercises also are excluded, except when prescribed by a physician and rendered by a physical therapist concurrent to, and as an integral part of, a comprehensive program of physical therapy.

45. Audiologist, speech therapist. Services of an audiologist or speech therapist, except when prescribed by a physician and rendered as a part of treatment addressed to the physical defect itself and not to any educational or occupational deficit.

46. Vision care. Eye exercises or visual training (orthoptics).

47. Eye and hearing examinations. Eye and hearing examinations except as specifically provided in paragraph C.2.p. of this chapter or except when rendered in connection with medical or surgical treatment of a covered illness or injury. Vision and hearing screening in connection with well-baby care is not excluded.

48. Prosthetic devices. Prostheses, except artificial limbs and eyes, or if an item is inserted surgically in the body as an integral part of a surgical procedure. All dental prostheses are excluded, except for those specifically required in connection with otherwise covered orthodontia directly related to the surgical correction of a cleft palate anomaly.

49. Orthopedic shoes. Orthopedic shoes, arch supports, shoe inserts, and other supportive devices for the feet, including special-ordered, custom-made built-up shoes, or regular shoes later built up.

50. Eyeglasses. Eyeglasses, spectacles, contact lenses, or other optical devices, except as specifically provided under subsection E.6. of this chapter.

51. Hearing aids. Hearing aids or other auditory sensory enhancing devices.

52. Telephonic services. Services or advice rendered by telephone or other telephonic device, including remote monitoring, except for transtelephonic monitoring of cardiac pacemakers.

53. Air conditioners, humidifiers, dehumidifiers, and purifiers.

54. Elevators or chair lifts.

55. Alterations. Alterations to living spaces or permanent features attached thereto, even when necessary to accommodate installation of covered durable medical equipment or to facilitate entrance or exit.

56. Clothing. Items of clothing or shoes, even if required by virtue of an allergy (such as cotton fabric as against synthetic fabric and vegetable dyed shoes).

57. Food, food substitutes. Food, food substitutes, vitamins, or other nutritional supplements, including those related to prenatal care.

58. Enuresis. Enuretic devices; enuretic conditioning programs.

59. RESERVED.

60. Autopsy and postmortem.

61. Camping. All camping even though organized for a specific therapeutic purpose (such as diabetic camp or a camp for emotionally disturbed children), and even though offered as a part of an otherwise covered treatment plan or offered through a CHAMPUS-approved facility.

62. Housekeeper, companion. Housekeeping, homemaker, or attendant services; sitter or companion.

63. Noncovered condition, unauthorized provider. All services and supplies (including inpatient institutional costs) related to a noncovered condition or treatment, or provided by an unauthorized provider.

64. Comfort or convenience. Personal, comfort, or convenience items such as beauty and barber services, radio, television, and telephone.

65. "Stop smoking" programs. Services and supplies related to "stop smoking" regimens.

66. Megavitamin psychiatric therapy, orthomolecular psychiatric therapy.

67. Transportation. All transportation except by ambulance, as specifically provided under section D. of this chapter, and except as authorized in subsection E.5. of this chapter.

68. Travel. All travel even though prescribed by a physician and even if its purpose is to obtain medical care, except as specified in subsection A.6.of this chapter in connection with a CHAMPUS-required physical examination.

69. Institutions. Services and supplies provided by other than a hospital, unless the institution has been approved specifically by OCHAMPUS. Nursing homes, intermediate care facilities, halfway houses, homes for the aged, or institutions of similar purpose are excluded from consideration as approved facilities under the Basic Program.

NOTE: In order to be approved under CHAMPUS, an institution must, in addition to meeting CHAMPUS standards, provide a level of care for which CHAMPUS benefits are payable.

70. Supplemental diagnostic services. Diagnostic services including clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results performed by civilian providers at the request of the attending Uniformed Service medical department physician (active duty or civil service).

71. Supplemental consultations. Consultations provided by civilian providers at the request of the attending Uniformed Services medical department physician (active duty or civil service).

72. Inpatient mental health services. Effective for care received on or after October 1, 1991, services in excess of 30 days in any fiscal year (or in an admission), in the case of a patient nineteen years of age or older, 45 days in any fiscal year (or in an admission) in the case of a patient under 19 years of age, or 150 days in any fiscal year (or in an admission) in the case of inpatient mental health services provided as residential treatment care, unless coverage for such services is granted by a waiver by the Director, OCHAMPUS, or a designee. In cases involving the day limitations, waivers shall be handled in accordance with paragraphs B.8. or B.9. of this chapter. For services prior to October 1, 1991, services in excess of 60 days in any calendar year unless additional coverage is granted by the Director, OCHAMPUS, or a designee.

73. Economic interest in connection with mental health admissions. Inpatient mental health services (including both acute care and RTC services) are excluded for care received when a patient is referred to a provider of such services by a physician (or other health care professional with authority to admit) who has an economic interest in the facility to which the patient is referred, unless a waiver is granted. Requests for waiver shall be considered under the same procedure and based on the same criteria as used for obtaining preadmission authorization (or continued stay authorization for

emergency admissions), with the only additional requirement being that the economic interest be disclosed as part of the request. The same reconsideration and appeals procedures that apply to day limit waivers shall also apply to decisions regarding requested waivers of the economic interest exclusion. However, a provider may appeal a reconsidered determination that an economic relationship constitutes an economic interest within the scope of the exclusion to the same extent that a provider may appeal determinations under paragraph I.3., Chapter 15. This exclusion does not apply to services under the Program for the Handicapped (Chapter 5 of this Regulation) or provided as partial hospital care. If a situation arises where a decision is made to exclude CHAMPUS payment solely on the basis of the provider's economic interest, the normal CHAMPUS appeals process will be available.

74. Not specifically listed. Services and supplies not specifically listed as a benefit in this Regulation. This exclusion is not intended to preclude extending benefits for those services or supplies specifically determined to be covered within the intent of this Regulation by the Director, OCHAMPUS, or a designee, even though not otherwise listed.

NOTE: The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it medically necessary or make the charge an allowable expense, even though it is not listed specifically as an exclusion.

H. Payment and liability for certain potentially excludable services under the Peer Review Organization program.

1. Applicability. This section provides special rules that apply only to services retrospectively determined under the Peer Review Organization (PRO) program (operated pursuant to Chapter 15) to be potentially excludable (in whole or in part) from the Basic Program under section G. of this chapter. Services may be excluded by reason of being not medically necessary (subsection G.1.) at an inappropriate level (subsection G.3.) custodial care (subsection G.7.) or other reason relative to reasonableness, necessity or appropriateness (which services shall throughout the remainder of this section, be referred to as "not medically necessary"). (Also throughout the remainder of the section, "services" includes items and "provider" includes supplier.) This section does not apply to coverage determinations made by OCHAMPUS or the fiscal intermediaries which are not based on medical necessity determinations made under the PRO program.

2. Payment for certain potentially excludable expenses. Services determined under the PRO program to be potentially excludable by reason of the exclusions in section G. of this chapter for not medically necessary services will not be determined to be excludable if neither the beneficiary to whom the services were provided nor the provider (institutional or individual) who furnished the services knew, or could reasonably have been expected to know, that the services were subject to those exclusions. Payment may be made for such services as if the exclusions did not apply.

3. Liability for certain excludable services. In any case in which items or services are determined excludable by the PRO program by reason of

being not medically necessary and payment may not be made under subsection H.2., above because the requirements of subsection H.2. are not met, the beneficiary may not be held liable (and shall be entitled to a full refund from the provider of the amount excluded and any cost-share amount already paid) if:

a. The beneficiary did not know and could not reasonably have been expected to know that the services were excludable by reason of being not medically necessary; and

b. The provider knew or could reasonably have been expected to know that the items or services were excludable by reason of being not medically necessary.

4. Criteria for determining that beneficiary knew or could reasonably have been expected to have known that services were excludable. A beneficiary who receives services excludable by reason of being not medically necessary will be found to have known that the services were excludable if the beneficiary has been given written notice that the services were excludable or that similar or comparable services provided on a previous occasion were excludable and that notice was given by the OCHAMPUS, CHAMPUS PRO or fiscal intermediary, a group or committee responsible for utilization review for the provider, or the provider who provided the services.

5. Criteria for determining that provider knew or could reasonably have been expected to have known that services were excludable. An institutional or individual provider will be found to have known or been reasonably expected to have known that services were excludable under this section under any one of the following circumstances:

a. The PRO or fiscal intermediary had informed the provider that the services provided were excludable or that similar or reasonably comparable services were excludable.

b. The utilization review group or committee for an institutional provider or the beneficiary's attending physician had informed the provider that the services provided were excludable.

c. The provider had informed the beneficiary that the services were excludable.

d. The provider had received written materials, including notices, manual issuances, bulletins, guides, directives, or other materials, providing notification of PRO screening criteria specific to the condition of the beneficiary. Attending physicians who are members of the medical staff of an institutional provider will be found to have also received written materials provided to the institutional provider.

e. The services that are at issue are the subject of what are generally considered acceptable standards of practice by the local medical community.

f. Preadmission authorization was available but not requested, or concurrent review requirements were not followed.

CHAPTER 6

AUTHORIZED PROVIDERS

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#Third Amendment (Ch 6, 6/24/94)

SECTION

#Fourth Amendment (Ch 8, 2/15/95)

(i) Professional staff. The center's professional staff is legally and professionally qualified for the performance of their professional responsibilities.

(j) Medical records. The center maintains full and complete written documentation of the services rendered to each woman admitted and each newborn delivered. A copy of the informed consent document required by subparagraph (c), above, which contains the original signature of the CHAMPUS beneficiary, signed and dated at the time of admission, must be maintained in the medical record of each CHAMPUS beneficiary admitted.

(k) Quality assurance. The center has an organized program for quality assurance which includes, but is not limited to, written procedures for regularly scheduled evaluation of each type of service provided, of each mother or newborn transferred to a hospital, and of each death within the facility.

(l) Governance and administration. The center has a governing body legally responsible for overall operation and maintenance of the center and a full-time employee who has authority and responsibility for the day-to-day operation of the center.

1. Psychiatric partial hospitalization programs. Psychiatric partial hospitalization programs must be either a distinct part of an otherwise authorized institutional provider or a freestanding program. The treatment program must be under the general direction of a psychiatrist employed by the partial hospitalization program to ensure medication and physical needs of all the patients are considered. The primary or attending provider must be a CHAMPUS authorized mental health provider, operating within the scope of his/her license. These categories include physicians, clinical psychologists, certified psychiatric nurse specialists, clinical social workers, marriage and family counselors, pastoral counselors and mental health counselors. CHAMPUS reimbursement is limited to programs complying with all requirements of Chapter 4, paragraph B.10. In addition, in order for a partial hospitalization program (PHP) to be authorized, the PHP shall comply with the following requirements:

(1) The PHP shall comply with the CHAMPUS Standards for Partial Hospitalization Programs and Facilities, as promulgated by the Director, OCHAMPUS.

(2) The PHP shall be specifically accredited by and remain in substantial compliance with standards issued by the Joint Commission on Accreditation of Healthcare Organizations under the Mental Health Manual (formerly the Consolidated Standards). NOTE: A one-time grace period is being allowed not to exceed October 1, 1994 for this provision only if the provider is already accredited under the JCAHO hospital standards. The provider must agree not to accept any new admissions for CHAMPUS patients for care beyond October 1, 1994, if accreditation and substantial compliance with the Mental Health Manual standards have not been obtained by that date.

(3) The PHP shall be licensed as a partial hospitalization program to provide PHP services within the applicable jurisdiction in which it operates.

(4) The PHP shall accept the CHAMPUS-allowable partial hospitalization program rate, as provided in Chapter 14, paragraph A.2.i., as payment in full for services provided.

(5) The PHP shall comply with all requirements of this section applicable to institutional providers generally concerning preauthorization, concurrent care review, claims processing, beneficiary liability, double coverage, utilization and quality review and other matters.

(6) The PHP must be fully operational and treating patients for a period of at least six months (with at least 30 percent minimum patient census) before an application for approval may be submitted. The PHP shall not be considered a CHAMPUS-authorized provider nor may any CHAMPUS benefits be paid to the facility for any services provided prior to the date the facility is approved by the Director, OCHAMPUS, or designee.

(7) All mental health services must be provided by a CHAMPUS-authorized mental health provider. [Exception: PHPs that employ individuals with master's or doctoral level degrees in a mental health discipline who do not meet the licensure, certification and experience requirements for a qualified mental health provider but are actively working toward licensure or certification, may provide services within the all-inclusive per diem rate but the individual must work under the clinical supervision of a fully qualified mental health provider employed by the PHP.] All other program services shall be provided by trained, licensed staff.

(8) The PHP shall ensure the provision of an active family therapy treatment component which assures that each patient and family participate at least weekly in family therapy provided by the institution and rendered by a CHAMPUS authorized mental health provider.

(9) The PHP must have a written agreement with at least one backup CHAMPUS-authorized hospital which specifies that the hospital will accept any and all CHAMPUS beneficiaries transferred for emergency mental health or medical/surgical care. The PHP must have a written emergency transport agreement with at least one ambulance company which specifies the estimated transport time to each backup hospital.

(10) The PHP shall enter into a participation agreement with the Director, OCHAMPUS, which shall include but which shall not be limited to the following provisions:

(a) The PHP agrees not to bill the beneficiary for services in excess of the cost-share or services for which payment is disallowed for failure to comply with requirements for preauthorization or concurrent care review.

(b) The PHP agrees not to bill the beneficiary for services excluded on the basis of Chapter 4, paragraphs G.1. (not medically necessary), G.3. (inappropriate level of care) or G.7. (custodial care), unless the beneficiary has

agreed in writing to pay for the care, knowing the specific care in question had been determined noncovered by CHAMPUS. (A general statement signed at admission as to financial liability does not fulfill this requirement.)

m. Hospice programs. Hospice programs must be Medicare approved and meet all Medicare conditions of participation (42 CFR Part 418) in relation to CHAMPUS patients in order to receive payment under the CHAMPUS program. A hospice program may be found to be out of compliance with a particular Medicare condition of participation and still participate in the CHAMPUS as long as the hospice is allowed continued participation in Medicare while the condition of noncompliance is being corrected. The hospice program can be either a public agency or private organization (or a subdivision thereof) which:

(1) Is primarily engaged in providing the care and services described under Section 199.4(e)(19) and makes such services available on a 24-hour basis.

(2) Provides bereavement counseling for the immediate family or terminally ill individuals.

(3) Provides for such care and services in individuals' homes, on an outpatient basis, and on a short-term inpatient basis, directly or under arrangements made by the hospice program, except that the agency or organization must:

(a) Ensure that substantially all the core services are routinely provided directly by hospice employees.

(b) Maintain professional management responsibility for all services which are not directly furnished to the patient, regardless of the location or facility in which the services are rendered.

(c) Provide assurances that the aggregate number of days of inpatient care provided in any 12-month period does not exceed 20 percent of the aggregate number of days of hospice care during the same period.

(d) Have an interdisciplinary group composed of the following personnel who provide the care and services described under Chapter 4.E.19 and who establish the policies governing the provision of such care/services:

1 a physician;

2 a registered professional nurse;

3 a social worker; and

4 a pastoral or other counselor.

(e) Maintain central clinical records on all patients.

(f) Utilize volunteers.

(g) The hospice and all hospice employees must be licensed in accordance with applicable Federal, State and local laws and regulations.

(h) The hospice must enter into an agreement with CHAMPUS in order to be qualified to participate and to be eligible for payment under the program. In this agreement the hospice and CHAMPUS agree that the hospice will:

1 Not charge the beneficiary or any other person for items or services for which the beneficiary is entitled to have payment made under the CHAMPUS hospice benefit.

2 Be allowed to charge the beneficiary for items or services requested by the beneficiary in addition to those that are covered under the CHAMPUS hospice benefit.

(i) Meet such other requirements as the Secretary of Defense may find necessary in the interest of the health and safety of the individuals who are provided care and services by such agency or organization.

C. INDIVIDUAL PROFESSIONAL PROVIDERS OF CARE

1. General. Individual professional providers of care are those providers who bill for their services on a fee-for-service basis and are not employed or

under a contract which provides for payment to the individual professional provider by an institutional provider. This category also includes those individuals who have formed professional corporations or associations qualifying as a domestic corporation under section 301.7701-5 of the Internal Revenue Service Regulations (reference (cc)). Such individual professional providers must be licensed or certified by the local licensing or certifying agency for the jurisdiction in which the care is provided; or in the absence of state licensure/certification, be a member of or demonstrate eligibility for full clinical membership in, the appropriate national or professional certifying association that sets standards for the profession of which the provider is a member. Services provided must be in accordance with good medical practice and prevailing standards of quality of care and within recognized utilization norms.

a. Licensing/Certification required, scope of license. Otherwise covered services shall be cost-shared only if the individual professional provider holds a current, valid license or certification to practice his or her profession in the jurisdiction where the service is rendered. Licensure/certification must be at the full clinical practice level. The services provided must be within the scope of the license, certification or other legal authorization. Licensure or certification is required to be a CHAMPUS authorized provider if offered in the jurisdiction where the service is rendered, whether such licensure or certification is required by law or provided on a voluntary basis. The requirement also applies for those categories of providers that would otherwise be exempt by the state because the provider is working in a non-profit, state-owned or church setting. Licensure/certification is mandatory for a provider to become a CHAMPUS-authorized provider.

b. Monitoring required. The Director, OCHAMPUS, or a designee, shall develop appropriate monitoring programs and issue guidelines, criteria, or norms necessary to ensure that CHAMPUS expenditures are limited to necessary medical supplies and services at the most reasonable cost to the government and beneficiary. The Director, OCHAMPUS, or a designee, also will take such steps as necessary to deter overutilization of services.

c. Christian Science. Christian Science practitioners and Christian Science nurses are authorized to provide services under CHAMPUS. Inasmuch as they provide services of an extramedical nature, the general criteria outlined above do not apply to Christian Science services (refer to subparagraph C.3.d.(2), below, regarding services of Christian Science practitioners and nurses).

d. Physician referral and supervision. Physician referral and supervision is required for the services of paramedical providers as listed in subparagraph C.3.c.8. and for pastoral counselors, and mental health counselors. Physician referral means that the physician must actually see the patient, perform an evaluation, and arrive at an initial diagnostic impression prior to referring the patient. Documentation is required of the physician's examination, diagnostic impression, and referral. Physician supervision means that the physician provides overall medical management of the case. The physician does not have to be physically located on the premises of the provider to whom the referral is made. Communication back to the referring physician is an indication of medical management.

e. Medical records: Individual professional providers must maintain adequate clinical records to substantiate that specific care was actually furnished, was medically necessary, and appropriate, and identify(ies) the individual(s) who provided the care. This applies whether the care is inpatient or outpatient. The minimum requirements for medical record documentation are set forth by the following:

(1) The cognizant state licensing authority;

(2) The Joint Commission on Accreditation of Healthcare Organizations, or other health care accreditation organizations as may be appropriate;

(3) Standards of practice established by national medical organizations; and

(4) This Regulation.

2. Interns and residents. Interns and residents may not be paid directly by CHAMPUS for services rendered to a beneficiary when their services are provided as part of their employment (either salaried or contractual) by a hospital or other institutional provider.

3. Types of providers. Subject to the standards of participation provisions of this Regulation, the following individual professional providers of medical care are authorized to provide services to CHAMPUS beneficiaries:

a. Physicians

(1) Doctors of Medicine (M.D.).

(2) Doctors of Osteopathy (D.O.).

b. Dentists. Except for covered oral surgery as specified in section E. of Chapter 4 of this Regulation, all otherwise covered services rendered by dentists require preauthorization.

(1) Doctors of Dental Medicine (D.M.D.).

(2) Doctors of Dental Surgery (D.D.S.).

c. Other allied health professionals. The services of the following individual professional providers of care are coverable on a fee-for-service basis provided such services are otherwise authorized in this or other chapters of this Regulation.

(1) Clinical psychologist. For purposes of CHAMPUS, a clinical psychologist is an individual who is licensed or certified by the state for the independent practice of psychology and:

(a) Possesses a doctoral degree in psychology from a regionally accredited university; and

(b) Has had 2 years of supervised clinical experience in psychological health services of which at least 1 year is post-doctoral and 1 year (may be the post-doctoral year) is in an organized psychological health service training program; or

(c) As an alternative to (a) and (b) above, is listed in the National Register of Health Service Providers in Psychology (reference (ee)).

(2) Doctors of Optometry.

(3) Doctors of Podiatry or Surgical Chiropody.

(4) Certified nurse midwives.

(a) A certified nurse midwife may provide covered care independent of physician referral and supervision, provided the nurse midwife is:

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1 Licensed, when required, by the local licensing agency for the jurisdiction in which the care is provided; and

2 Certified by the American College of Nurse Midwives. To receive certification, a candidate must be a registered nurse who has completed successfully an educational program approved by the American College of Nurse Midwives, and passed the American College of Nurse Midwives National Certification Examination.

(b) The services of a registered nurse who is not a certified nurse midwife may be authorized only when the patient has been referred for care by a licensed physician and a licensed physician provides continuing supervision of the course of care. A lay midwife who is neither a certified nurse midwife nor a registered nurse is not a CHAMPUS-authorized provider, regardless of whether the services rendered may otherwise be covered.

(5) Certified nurse practitioner. Within the scope of applicable licensure or certification requirements, a certified nurse practitioner may provide covered care independent of physician referral and supervision, provided the nurse practitioner is:

(a) A licensed, registered nurse; and

(b) Specifically licensed or certified as a nurse practitioner by the state in which the care was provided, if the state offers such specific licensure or certification; or

(c) Certified as a nurse practitioner (certified nurse) by a professional organization offering certification in the speciality of practice, if the state does not offer specific licensure or certification for nurse practitioners.

(6) Certified Clinical Social Worker. A clinical social worker may provide covered services independent of physician referral and supervision, provided the clinical social worker:

(a) Is licensed or certified as a clinical social worker by the jurisdiction where practicing; or, if the jurisdiction does not provide for licensure or certification of clinical social workers, is certified by a national professional organization offering certification of clinical social workers; and

(b) Has at least a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education; and

(c) Has had a minimum of 2 years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate clinical setting, as determined by the Director, OCHAMPUS, or a designee.

NOTE: Patients' organic medical problems must receive appropriate concurrent management by a physician.

(7) Certified psychiatric nurse specialist. A certified psychiatric nurse specialist may provide covered care independent of physician referral and supervision. For purposes of CHAMPUS, a certified psychiatric nurse specialist is an individual who:

(a) Is a licensed, registered nurse; and

(b) Has at least a master's degree in nursing from a regionally accredited institution with a specialization in psychiatric and mental health nursing; and

(c) Has had at least 2 years of post-master's degree practice in the field of psychiatric and mental health nursing, including an average of 8 hours of direct patient contact per week; or

(d) Is listed in a CHAMPUS-recognized, professionally sanctioned listing of clinical specialists in psychiatric and mental health nursing.

(8) Certified physician assistant. A physician assistant may provide care under general supervision of a physician (see Chapter 14 G.1.c. for limitations on reimbursement). For purposes of CHAMPUS, a physician assistant must meet the applicable state requirements governing the qualifications of physician assistants and at least one of the following conditions:

(a) Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians, or

(b) Has satisfactorily completed a program for preparing physician assistants that:

1 Was at least 1 academic year in length;

2 Consisted of supervised clinical practice and at least 4 months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and

3 Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation; or

(c) Has satisfactorily completed a formal educational program for preparing physician assistants that does not meet the requirements of subparagraph (1)(b) of this paragraph and had been assisting primary care physicians for a minimum of 12 months during the 18-month period immediately preceding January 1, 1987.

(9) Other individual paramedical providers. The services of the following individual professional providers of care to be considered for benefits on a fee-for-service basis may be provided only if the beneficiary is referred by a physician for the treatment of a medically-diagnosed condition and a physician must also provide continuing and ongoing oversight and supervision of the program or episode of treatment provided by these individual paramedical providers.

(a) Licensed registered nurses.

(b) Licensed practical or vocational nurses.

(c) Licensed registered physical therapists.

(d) Audiologists.

(e) Speech therapists (speech pathologists).

d. Extramedical individual providers. Extramedical individual providers are those who do counseling or nonmedical therapy and whose training and therapeutic concepts are outside the medical field. The services of extramedical individual professionals are coverable following the CHAMPUS determined allowable charge methodology provided such services are otherwise authorized in this or other chapters of the regulation.

(1) Certified marriage and family therapists. For the purposes of CHAMPUS, a certified marriage and family therapist is an individual who meets the following requirements:

(a) Recognized graduate professional education with the minimum of an earned master's degree from a regionally accredited educational institution in an appropriate behavioral science field, mental health discipline; and

(b) The following experience:

1 Either 200 hours of approved supervision in the practice of marriage and family counseling, ordinarily to be completed in a 2- to 3-year period, of which at least 100 hours must be in individual supervision. This supervision will occur preferably with more than one supervisor and should include a continuous process of supervision with at least three cases; and

2 1,000 hours of clinical experience in the practice of marriage and family counseling under approved supervision, involving at least 50 different cases; or

3 150 hours of approved supervision in the practice of psychotherapy, ordinarily to be completed in a 2- to 3-year period, of which at least 50 hours must be individual supervision; plus at least 50 hours of approved individual supervision in the practice of marriage and family counseling, ordinarily to be completed within a period of not less than 1 nor more than 2 years; and

4 750 hours of clinical experience in the practice of psychotherapy under approved supervision involving at least 30 cases; plus at least 250 hours of clinical practice in marriage and family counseling under approved supervision, involving at least 20 cases; and

(c) Is licensed or certified to practice as a marriage and family therapist by the jurisdiction where practicing (see C.3.d.(4) of this part for more specific information regarding licensure); and

(d) Agrees that a patients' organic medical problems must receive appropriate concurrent management by a physician.

(e) Agrees to accept the CHAMPUS determined allowable charge as payment in full, except for applicable deductibles and cost-shares, and hold CHAMPUS beneficiaries harmless for noncovered care (i.e., may not bill a beneficiary for noncovered care, and may not balance bill a beneficiary for amounts above the allowable charge). The certified marriage and family therapist must enter into a participation agreement with the Office of CHAMPUS within which the certified marriage and family therapist agrees to all provisions specified above.

(f) As of the effective date of termination, the certified marriage and family therapist, will no longer be recognized as an authorized provider under CHAMPUS. Subsequent to termination, the certified marriage and family therapist may only be reinstated as an authorized CHAMPUS extramedical provider by entering into a new participation agreement as a certified marriage and family therapist.

(2) Pastoral counselors. For the purposes of CHAMPUS a pastoral counselor is an individual who meets the following requirements:

(a) Recognized graduate professional education with the minimum of an earned master's degree from a regionally accredited educational institution in an appropriate behavioral science field, mental health discipline; and

(b) The following experience:

1 Either 200 hours of approved supervision in the practice of pastoral counseling, ordinarily to be completed in a 2- to 3-year period, of which at least 100 hours must be in individual supervision. This supervision will occur preferably with more than one supervisor and should include a continuous process of supervision with at least three cases; and

2 1,000 hours of clinical experience in the practice of pastoral counseling under approved supervision, involving at least 50 different cases; or

3 150 hours of approved supervision in the practice of psychotherapy, ordinarily to be completed in a 2- to 3-year period, of which at least 50 hours must be individual supervision; plus at least 50 hours of approved individual supervision in the practice of pastoral counseling, ordinarily to be completed within a period of not less than 1 nor more than 2 years; and

4 750 hours of clinical experience in the practice of psychotherapy under approved supervision involving at least 30 cases; plus at least 250 hours of clinical practice in pastoral counseling under approved supervision, involving at least 20 cases; and

(c) Is licensed or certified to practice by the jurisdiction where practicing (see C.3.d.(4) of this part for more specific information regarding licensure); and

(d) The services of a pastoral counselor meeting the above requirements are coverable following the CHAMPUS determined allowable charge methodology, under the following specified conditions:

1 The CHAMPUS beneficiary must be referred for therapy by a physician; and

2 A physician is providing ongoing oversight and supervision of the therapy being provided; and

3 The pastoral counselor must certify on each claim for reimbursement that a written communication has been made or will be made to the referring physician of the results of the treatment. Such communication will be made at the end of the treatment, or more frequently, as required by the referring physician (refer to Chapter 7).

(e) Because of the similarity of the requirements for licensure, certification, experience and education a pastoral counselor may elect to be authorized under CHAMPUS as a certified marriage and family therapist, and as such, be subject to all previously defined criteria for the certified marriage and family therapist category, to include acceptance of the CHAMPUS determined allowable charge as payment in full, except for applicable deductibles and cost-shares, (i.e., balance billing of a beneficiary above the allowable charge is prohibited; may not bill beneficiary for noncovered care). The pastoral counselor must also agree to enter into the same participation agreement as a certified marriage and family therapist with the Office of CHAMPUS within which the pastoral counselor agrees to all provisions, including licensure, national association membership and conditions upon termination, outlined above for certified marriage and family therapists.

NOTE: No dual status will be recognized by the Office of CHAMPUS. Pastoral counselors must elect to become one of the categories of extramedical CHAMPUS providers specified above. Once authorized as either a pastoral counselor,

or a certified marriage and family therapist, claims review and reimbursement will be in accordance with the criteria established for the elected provider category.

(3) Mental Health Counselor. For the purposes of CHAMPUS, a mental health counselor is an individual who meets the following requirements:

(a) Minimum of a master's degree in mental health counseling or allied mental health field from a regionally accredited institution; and

(b) Two years of post-master's experience which includes 3000 hours of clinical work and 100 hours of face-to-face supervision; and

(c) Is licensed or certified to practice as a mental health counselor by the jurisdiction where practicing (see C.3.d.(4) of this part for more specfic information); and

(d) May only be reimbursed when:

1 The CHAMPUS beneficiary is referred for therapy by a physician; and

2 A physician is providing ongoing oversight and supervision of the therapy being provided; and

3 The mental health counselor certifies on each claim for reimbursement that a written communication has been made or will be made to the referring physician of the results of the treatment. Such communication will be made at the end of the treatment, or more frequently, as required by the referring physician (refer to Chapter 7).

(4) The following additional information applies to each of the above categories of extramedical individual providers:

(a) These providers must also be licensed or certified to practice as a certified marriage and family therapist, pastoral counselor or mental health counselor by the jurisdiction where practicing. In jurisdictions that do not provide for licensure or certification, the provider must be certified by or eligible for full clinical membership in the appropriate national professional association that sets standards for the specific profession.

(b) Grace period for therapists or counselors in states where licensure/certification is optional. CHAMPUS is providing a grace period for those therapists or counselors who did not obtain optional licensure/certification in their jurisdiction, not realizing it was a CHAMPUS requirement for authorization. The exemption by state law for pastoral counselors may have misled this group into thinking licensure was not required. The same situation may have occurred with the other therapist or counselor categories. This grace period pertains only to the licensure/certification requirement, applies only to therapists or counselors who

are already approved as of October 29, 1990, and only in those areas where the licensure/certification is optional. Any therapist or counselor who is not licensed/certified in the state in which he/she is practicing by August 1, 1991, will be terminated under the provisions of Section 199.9 of this part. This grace period does not change any of the other existing requirements which remain in effect. During this grace period, membership or proof of eligibility for full clinical membership in a recognized professional association is required for those therapists or counselors who are not licensed or certified by the state. The following organizations are recognized for therapists or counselors at the level indicated: full clinical member of the American Association of Marriage and Family Therapy; membership at the fellow or diplomate level of the American Association of Pastoral Counselors; and membership in the National Academy of Certified Clinical Mental Health Counselors. Acceptable proof of eligibility for membership is a letter from the appropriate certifying organization. This opportunity for delayed certification/licensure is limited to the counselor or therapist category only as the language in all of the other provider categories has been consistent and unmodified from the time each of the other provider categories were added. The grace period does not apply in those states where licensure is mandatory.

(5) Christian Science practitioners and Christian Science nurses. CHAMPUS cost shares the services of Christian Science practitioners and nurses. In order to bill as such, practitioners or nurses must be listed or be eligible for listing in the Christian Science Journal at the time the service is provided.

D. OTHER PROVIDERS

Certain medical supplies and services of an ancillary or supplemental nature are coverable by CHAMPUS, subject to certain controls. This category of provider includes the following:

1. Independent laboratory. Laboratory services of independent laboratories may be cost-shared if the laboratory is approved for participation under Medicare and certified by the Medicare Bureau, Health Care Financing Administration.

2. Suppliers of portable x-ray services. Such suppliers must meet the conditions of coverage of the Medicare program, set forth in the Medicare regulations (reference (h)), or the Medicaid program in that state in which the covered service is provided.

3. Pharmacies. Pharmacies must meet the applicable requirements of state law in the state in which the pharmacy is located.

4. Ambulance companies. Such companies must meet the requirements of state and local laws in the jurisdiction in which the ambulance firm is licensed.

5. Medical equipment firms, medical supply firms. As determined by the Director, OCHAMPUS, or a designee.

6. Mammography Suppliers. Mammography services may be cost-shared only if the supplier is certified by Medicare for participation as a mammography supplier, or is certified by the American College of Radiology as having met its mammography supplier standards.

E. IMPLEMENTING INSTRUCTIONS

The Director, OCHAMPUS, or a designee, shall issue CHAMPUS policies, instructions, procedures, and guidelines, as may be necessary to implement the intent of this chapter.

F. EXCLUSION

Regardless of any provision in this chapter, a provider who is suspended, excluded, or terminated under Chapter 9 of this Regulation is specifically excluded as an authorized CHAMPUS provider.

CHAPTER 14

PROVIDER REIMBURSEMENT METHODS

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SECTION

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G. Reimbursement of hospice programs. Hospice care will be reimbursed at one of four predetermined national CHAMPUS rates based on the type and intensity of services furnished to the beneficiary. A single rate is applicable for each day of care except for continuous home care where payment is based on the number of hours of care furnished during a 24-hour period. These rates will be adjusted for regional differences in wages using wage indices for hospice care.

1. National hospice rates. CHAMPUS will use the national hospice rates for reimbursement of each of the following levels of care provided by or under arrangement with a CHAMPUS approved hospice program:

a. Routine home care. The hospice will be paid the routine home care rate for each day the patient is at home, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

b. Continuous home care. The hospice will be paid the continuous home care rate when continuous home care is provided. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate.

(1) A minimum of 8 hours of care must be provided within a 24-hour day starting and ending at midnight.

(2) More than half of the total actual hours being billed for each 24-hour period must be provided by either a registered or licensed practical nurse.

(3) Homemaker and home health aide services may be provided to supplement the nursing care to enable the beneficiary to remain at home.

(4) For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to 24 hours a day.

c. Inpatient respite care. The hospice will be paid at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care.

(1) Payment for respite care may be made for a maximum of 5 days at a time, including the date of admission but not counting the date of discharge. The necessity and frequency of respite care will be determined by the hospice interdisciplinary group with input from the patient's attending physician and the hospice's medical director.

(2) Payment for the sixth and any subsequent days is to be made at the routine home care rate.

d. General inpatient care. Payment at the inpatient rate will be made when general inpatient care is provided for pain control or acute or chronic symptom management which cannot be managed in other settings. None of the other

fixed payment rates (i.e., routine home care) will be applicable for a day on which the patient receives general inpatient care except on the date of discharge.

e. Date of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

2. Use of Medicare rates. CHAMPUS will use the most current Medicare rates to reimburse hospice programs for services provided to CHAMPUS beneficiaries. It is CHAMPUS' intent to adopt changes in the Medicare reimbursement methodology as they occur; e.g., Medicare's adoption of an updated, more accurate wage index.

3. Physician reimbursement. Payment is dependent on the physician's relationship with both the beneficiary and the hospice program.

a. Physicians employed by, or contracted with, the hospice.

(1) Administrative and supervisory activities (i.e., establishment, review and updating of plans of care, supervising care and services, and establishing governing policies) are included in the adjusted national payment rate.

(2) Direct patient care services are paid in addition to the adjusted national payment rate.

(a) Physician services will be reimbursed an amount equivalent to 100 percent of the CHAMPUS' allowable charge; i.e., there will be no cost-sharing and/or deductibles for hospice physician services.

(b) Physician payments will be counted toward the hospice cap limitation.

b. Independent attending physician. Patient care services rendered by an independent attending physician (a physician who is not considered employed by or under contract with the hospice) are not part of the hospice benefit.

(1) Attending physician may bill in his/her own right.

(2) Services will be subject to the appropriate allowable charge methodology.

(3) Reimbursement is not counted toward the hospice cap limitation.

(4) Services provided by an independent attending physician must be coordinated with any direct care services provided by hospice physicians.

(5) The hospice must notify the CHAMPUS contractor of the name of the physician whenever the attending physician is not a hospice employee.

c. Voluntary physician services. No payment will be allowed for physician services furnished voluntarily (both physicians employed by, and under contract with, the hospice and independent attending physicians). Physicians may not discriminate against CHAMPUS beneficiaries; e.g., designate all services rendered to non-CHAMPUS patients as volunteer and at the same time bill for CHAMPUS patients.

4. Unrelated medical treatment. Any covered CHAMPUS services not related to the treatment of the terminal condition for which hospice care was elected will be paid in accordance with standard reimbursement methodologies; i.e., payment for these services will be subject to standard deductible and cost-sharing provisions under the CHAMPUS. A determination must be made whether or not services provided are related to the individual's terminal illness. Many illnesses may occur when an individual is terminally ill which are brought on by the underlying condition of the patient. For example, it is not unusual for a terminally ill patient to develop pneumonia or some other illness as a result of his or her weakened condition. Similarly, the setting of bones after fractures occur in a bone cancer patient would be treatment of a related condition. Thus, if the treatment or control of an upper respiratory tract infection is due to the weakened state of the terminal patient, it will be considered a related condition, and as such, will be included in the hospice daily rates.

5. Cap amount. Each CHAMPUS-approved hospice program will be subject to a cap on aggregate CHAMPUS payments from November 1 through October 31 of each year, hereafter known as "the cap period."

a. The cap amount will be adjusted annually by the percent of increase or decrease in the medical expenditure category of the Consumer Price Index for all urban consumers (CPI-U).

b. The aggregate cap amount (i.e., the statutory cap amount times the number of CHAMPUS beneficiaries electing hospice care during the cap period) will be compared with total actual CHAMPUS payments made during the same cap period.

c. Payments in excess of the cap amount must be refunded by the hospice program. The adjusted cap amount will be obtained from the Health Care Financing Administration (HCFA) prior to the end of each cap period.

d. Calculation of the cap amount for a hospice which has not participated in the program for an entire cap year (November 1 through October 31) will be based on a period of at least 12 months but no more than 23 months.

For example, the first cap period for a hospice entering the program on October 1, 1994, would run from October 1, 1994 through October 31, 1995. Similarly, the first cap period for hospice providers entering the program after November 1, 1993 but before November 1, 1994 would end October 31, 1995.

6. Inpatient limitation. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days, both for general inpatient care and respite care, may not exceed 20 percent of the aggregate total number of days of hospice care provided to all CHAMPUS beneficiaries during the same period.

a. If the number of days of inpatient care furnished to CHAMPUS beneficiaries exceeds 20 percent of the total days of hospice care to CHAMPUS beneficiaries, the total payment for inpatient care is determined as follows:

(1) Calculate the ratio of the maximum number of allowable inpatient days to the actual number of inpatient care days furnished by the hospice to Medicare patients.

(2) Multiply this ratio by the total reimbursement for inpatient care made by the CHAMPUS contractor.

(3) Multiply the number of actual inpatient days in excess of the limitation by the routine home care rate.

(4) Add the amounts calculated in paragraphs G.6.a.(2) and (3) of this section.

b. Compare the total payment for inpatient care calculated in paragraph G.6.a.(4) above to actual payments made to the hospice for inpatient care during the cap period.

c. Payments in excess of the inpatient limitation must be refunded by the hospice program.

7. Hospice reporting responsibilities. The hospice is responsible for reporting the following data within 30 days after the end of the cap period:

a. Total reimbursement received and receivable for services furnished CHAMPUS beneficiaries during the cap period, including physician's services not of an administrative or general supervisory nature.

b. Total reimbursement received and receivable for general inpatient care and inpatient respite care furnished to CHAMPUS beneficiaries during the cap period.

c. Total number of inpatient days furnished to CHAMPUS hospice patients (both general inpatient and inpatient respite days) during the cap period.

d. Total number of CHAMPUS hospice days (both inpatient and home care) during the cap period.

e. Total number of beneficiaries electing hospice care. The following rules must be adhered to by the hospice in determining the number of CHAMPUS beneficiaries who have elected hospice care during the period:

(1) The beneficiary must not have been counted previously in either another hospice's cap or another reporting year.

(2) The beneficiary must file an initial election statement during the period beginning September 28 of the previous cap year through September 27 of the current cap year in order to be counted as an electing CHAMPUS beneficiary during the current cap year.

(3) Once a beneficiary has been included in the calculation of a hospice cap amount, he or she may not be included in the cap for that hospice again, even if the number of covered days in a subsequent reporting period exceeds that of the period where the beneficiary was included.

(4) There will be proportional application of the cap amount when a beneficiary elects to receive hospice benefits from two or more different CHAMPUS-certified hospices. A calculation must be made to determine the percentage of the patient's length of stay in each hospice relative to the total length of hospice stay.

8. Reconsideration of cap amount and inpatient limit. A hospice dissatisfied with the contractor's calculation and application of its cap amount and/or inpatient limitation may request and obtain a contractor review if the amount of program reimbursement in controversy -- with respect to matters which the hospice has a right to review -- is at least $1000. The administrative review by the contractor of the calculation and application of the cap amount and inpatient limitation is the only administrative review available. These calculations are not subject to the appeal procedures set forth in Chapter 10. The methods and standards for calculation of the hospice payment rates established by CHAMPUS, as well as questions as to the validity of the applicable law, regulations or CHAMPUS decisions, are not subject to administrative review, including the appeal procedures of Chapter 10.

9. Beneficiary cost-sharing. There are no deductibles under the CHAMPUS hospice benefit. CHAMPUS pays the full cost of all covered services for the terminal illness, except for small cost-share amounts which may be collected by the individual hospice for outpatient drugs and biologicals and inpatient respite care.

a. The patient is responsible for 5 percent of the cost of outpatient drugs or $5 toward each prescription, whichever is less. Additionally, the cost of prescription drugs (drugs or biologicals) may not exceed that which a prudent

buyer would pay in similar circumstances; that is, a buyer who refuses to pay more than the going price for an item or service and also seeks to economize by minimizing costs.

b. For inpatient respite care, the cost-share for each respite care day is equal to 5 percent of the amount CHAMPUS has estimated to be the cost of respite care, after adjusting the national rate for local wage differences.

c. The amount of the individual cost-share liability for respite care during a hospice cost-share period may not exceed the Medicare inpatient hospital deductible applicable for the year in which the hospice cost-share period began. The individual hospice cost-share period begins on the first day an election is in effect for the beneficiary and ends with the close of the first period of 14 consecutive days on each of which an election is not in effect for the beneficiary.

H. REIMBURSEMENT OF INDIVIDUAL HEALTH-CARE PROFESSIONALS AND OTHER NON-INSTITUTIONAL HEALTH-CARE PROVIDERS

The CHAMPUS-determined reasonable charge (the amount allowed by CHAMPUS) for the service of an individual health-care professional or other non-institutional health-care provider (even if employed by or under contract to an institutional provider) shall be determined by one of the following methodologies, that is, whichever is in effect in the specific geographic location at the time covered services and supplies are provided to a CHAMPUS beneficiary.

1. Allowable charge method.

a. Introduction

(1) In general. The allowable charge method is the preferred and primary method for reimbursement of individual health care professionals and other non-institutional health care providers (covered by 10 U.S.C. 1079(h)(1)). The allowable charge for authorized care shall be the lower of the billed charge or the local CHAMPUS Maximum Allowable Charge (CMAC) level.

(2) CHAMPUS Maximum Allowable Charge. Beginning in calendar year 1992, prevailing charge levels and appropriate charge levels will be calculated on a national level. There will then be calculated a national CHAMPUS Maximum Allowable Charge (CMAC) level for each procedure, which shall be the lesser of the national prevailing charge level or the national appropriate charge level. The national CMAC will then be adjusted for localities in accordance with paragraph G.1.d., of this Chapter.

(3) Differential for Participating Providers. Beginning in calendar year 1994, there shall be a differential in national and local CMACs based on whether the provider is a participating provider or a nonparticipating provider. The differential shall be calculated so that the CMAC for the nonparticipating providers is 95 percent of the CMAC for the participating providers. To assure the effectiveness of the several phase-in and waiver

provisions set forth in paragraphs G.1.c., and G.1.d., of this Chapter, beginning in calendar year 1994, there will first be calculated the national and local CMACs for nonparticipating providers. For purposes of this calculation, the identification of overpriced procedures called for in pargagraph G.1.C.a., of this Chapter and the calculation of appropriate charge levels for such overpriced procedures called for in paragraph G.1.D.(2), of this Chapter shall use as the Medicare fee component of the comparisons and calculations the fee level applicable to Medicare nonparticipating providers, which is 95 percent of the basic fee level. After nonparticipating provider local CMACs are calculated (including consideration of special phase-in rules and waiver rules in paragraph G.1.d., of this Chapter) participating provider local CMACs will be calculated so that nonparticipating provider local CMACs are 95 percent of participating provider local CMACs. (For more information on the Participating Provider Program, see Chapter 6.A.8).

(4) Limits on balance billing by nonparticipating providers. Nonparticipating providers may not balance bill a beneficiary an amount which exceeds the applicable balance billing limit. The balance billing limit shall be the same percentage as the Medicare limiting charge percentage for nonparticipating physicians. The balance billing limit may be waived by the Director, OCHAMPUS on a case-by-case basis if requested by the CHAMPUS beneficiary (or sponsor) involved. A decision by the Director to waive or not waive the limit in any particular case is not subject to the appeal and hearing procedures of Chapter 10., of this regulation.

b. Prevailing charge level.

(1) Beginning in calendar year 1992, the prevailing charge level shall be calculated on a national basis.

(2) The national prevailing charge level referred to in paragraph G.1.b.(1) of this section is the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the base period. The 80th percentile of charges shall be determined on the basis of statistical data and methodology acceptable to the Director, OCHAMPUS (or a designee).

(3) For purposes of paragraph G.1.b.(2) of this section, the base period shall be a period of 12 calendar months and shall be adjusted once a year, unless the Director, OCHAMPUS determines that a different period for adjustment is appropriate and publishes a notice to that effect in the Federal Register.

c. Appropriate charge level. Beginning in calendar year 1992, the appropriate charge level for each procedure is the product of the two-step process set forth in paragraphs G.1.(c)(1) and (2) of this Chapter. This process involves comparing the prior year's CMAC with the fully phased in Medicare fee. For years after the Medicare fee has been fully phased in, the comparison shall be to the current Medicare fee. For any particular procedure

for which comparable Medicare fee and CHAMPUS data are unavailable, but for which alternative data are available that the Director, OCHAMPUS (or designee) determines provide a reasonable approximation of relative value or price, the comparison may be based on such alternative data.

(1) Step 1: procedures classified. All procedures are classified into one of three categories, as follows:

(a) Overpriced procedures. These are the procedures for which the prior year's national CMAC exceeds the Medicare fee.

(b) Other procedures. These are procedures subject to the allowable charge method that are not included in either the overpriced procedures group or the underpriced procedures group.

(c) Underpriced procedures. These are the procedures for which the prior year's national CMAC is less than the Medicare fee.

(2) Step 2: calculating appropriate charge levels. For each year, appropriate charge levels will be calculated by adjusting the prior year's CMAC as follows:

(a) For overpriced procedures, the appropriate charge level for each procedure shall be the prior year's CMAC, reduced by the lesser of: the percentage by which it exceeds the Medicare fee or fifteen percent.

(b) For other procedures, the appropriate charge level for each procedure shall be the same as the prior year's CMAC.

(c) For underpriced procedures, the appropriate charge level for each procedure shall be the prior year's CMAC, increased by the lesser of: the percentage by which it is exceeded by the Medicare fee or the Medicare Economic Index.

c. Special rule for cases in which the CHAMPUS appropriate charge was prematurely reduced. In any case in which a recalculation of the Medicare fee results in a Medicare rate higher than the CHAMPUS appropriate charge for a procedure that had been considered an overpriced procedure, the reduction in the CHAMPUS appropriate charge shall be restored up to the level of the recalculated Medicare rate.

d. Calculating CHAMPUS Maximum Allowable Charge levels for localities.

(1) In general. The national CHAMPUS Maximum Allowable Charge level for each procedure will be adjusted for localities using the same (or similar) geographical areas and the same geographic adjustment factors as are used for determining allowable charges under Medicare.

(2) Special locality-based phase-in provision.

#First Amendment (Ch 8, 2/15/95)

(a) In general. Beginning with the recalculation of CMACs for calendar year 1993, the CMAC in a locality will not be less than 72.25 percent of the maximum charge level in effect for that locality on December 31, 1991. For recalculations of CMACs for calendar years after 1993, the CMAC in a locality will not be less than 85 percent of the CMAC in effect for that locality at the end of the prior calendar year.

(b) Exception. The special locality-based phase-in provision established by Section G.1.d.(2)(a) of this Chapter shall not be applicable in the case of any procedure code for which there were not CHAMPUS claims in the locality accounting for at least 50 services.

(3) Special locality-based waivers of reductions to assure adequate access to care. Beginning with the recalculation of CMACs for calendar year 1993, in the case of any procedure classified as an overpriced procedure pursuant to section G.1.c.(1)(a) of this Chapter, a reduction in the CMAC in a locality below the level in effect at the end of the previous calendar year that would otherwise occur pursuant to sections G.1.c., and G.1.d., of this Chapter may be waived pursuant to this section G.1.c.(3).

(a) Waiver based on balance billing rates. Except as provided in section G.1.d.(3)(b) of this Chapter such a reduction will be waived if there has been excessive balance billing in the locality for the procedure involved. For this purpose, the extent of balance billing will be determined based on a review of all services under the procedure code involved in the prior year (or most recent period for which data are available). If the number of services for which balance billing was not required was less than 60 percent of all services provided, the Director will determine that there was an excessive balance billing with respect to that procedure in that locality and will waive the reduction in the CMAC that would otherwise occur. A decision by the Director to waive or not to waive the reduction is not subject to the appeal and hearing procedures of Chapter 10 of this regulation.

(b) Exception. As an exception to section G.1.d.(3)(a) of this Chapter, the waiver required by that section shall not be applicable in the case of any procedure code for which there were not CHAMPUS claims in the locality accounting for at least 50 services. A waiver may, however, be granted in such cases pursuant to section G.1.d.(3)(c) of this Chapter.

(c) Waiver based on other evidence that adequate access to care would be impaired. The Director, OCHAMPUS may waive a reduction that would otherwise occur (or restore a reduction that was already taken) if the Director determines that available evidence shows that the reduction would impair adequate access. For this purpose, such evidence may include consideration of the number of providers in the locality who provide the affected services, the number of such providers who are CHAMPUS Participating Providers, the number of CHAMPUS beneficiaries in the area, and other relevant factors. Providers or beneficiaries in a locality may submit to the Director, OCHAMPUS a petition, together with appropriate documentation regarding relevant factors, for a determination that adequate access would be impaired. The Director, OCHAMPUS will consider and respond to all such petitions. Petitions may be filed at any

time. Any petition received by the date which is 120 days prior to the implementation of a recalculation of CMACs will be assured of consideration prior that implementation. The Director, OCHAMPUS may establish procedures for handling petitions. A decision by the Director to waive or not to waive a reduction is not subject to the appeal and hearing procedures of Chapter 10 of this regulation.

e. Special rules for 1991.

(1) Prevailing charge levels for care provided on or after January 1, 1991, and before the 1992 prevailing charge levels take effect shall be the same as those in effect on December 31, 1990, except that prevailing charge levels for care provided on or after October 7, 1991 shall be those established pursuant to this paragraph G.1.e. of this section.

(2) Appropriate charge levels will be established for each locality for which a prevailing charge level was in effect immediately prior to October 7, 1991. For each procedure, the appropriate charge level shall be the prevailing charge level in effect immediately prior to October 7, 1991, adjusted as provided in G.1.e.(2)(a) through (c) of this section.

(a) For each overpriced procedure, the level shall be reduced by fifteen percent. For this purpose, overpriced procedures are the procedures determined by the Physician Payment Review Commission to be overvalued pursuant to the process established under the Medicare program, other procedures considered overvalued in the Medicare program (for which Congress directed reductions in Medicare allowable levels for 1991), radiology procedures and pathology procedures.

(b) For each other procedure, the level shall remain unchanged. For this purpose, other procedures are procedures which are not overpriced procedures or primary care procedures.

(c) For each primary care procedure, the level shall be adjusted by the MEI, as the MEI is applied to Medicare prevailing charge levels. For this purpose, primary care procedures include maternity care and delivery services and well baby care services.

f. Special transition rule for 1992.

(1) For purposes of calculating the national appropriate charge levels for 1992, the prior year's appropriate charge level for each service will be considered to be the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the base period of July 1, 1986 to June 30, 1987 (determined as under paragraph G.1.b.(2) of this section), adjusted to calendar year 1991 based on the adjustments made for maximum CHAMPUS prevailing charge levels through 1990 and the application of paragraph G.1.e. of this section for 1991.

(2) The adjustment to calendar year 1991 of the product of paragraph G.1.f.(1) of this section shall be as follows:

(a) For procedures other than those described in paragraph G.1.f.(2)(b) of this section, the adjustment to 1991 shall be on the same basis as that provided under paragraph G.1.e. of this section.

(b) For any procedure that was considered an overpriced procedure for purposes of the 1991 prevailing charge levels under paragraph G.1.e. of this section for which the resulting 1991 prevailing charge level was less than 150 percent of the Medicare converted relative value unit, the adjustment to 1991 for purposes of the special transition rule for 1992 shall be as if the procedure had been treated under paragraph G.1.e.(2)(b) of this section for purposes of the 1991 prevailing charge level.

g. Adjustments and procedural rules.

(1) The Director, OCHAMPUS may make adjustments to the appropriate charge levels calculated pursuant to paragraphs G.1.c. and G.1.e. of this section to correct any anomalies resulting from data or statistical factors, significant differences between Medicare-relevant information and CHAMPUS-relevant considerations or other special factors that fairness requires be specially recognized. However, no such adjustment may result in reducing an appropriate charge level.

(2) The Director, OCHAMPUS will issue procedural instructions for administration of the allowable charge method.

h. Clinical laboratory services. The allowable charge for clinical diagnostic laboratory test services shall be calculated in the same manner as allowable charges for other individual health care providers are calculated pursuant to paragraphs G.1.a. through G.1.d. of this Chapter, with the following exceptions and clarifications.

(1) The calculation of national prevailing charge levels, national appropriate charge levels and national CMACs for laboratory services shall begin in calendar year 1993. For purposes of the 1993 calculation, the prior year year's national appropriate charge level or national prevailing charge level shall be the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the period July 1, 1991, through June 30, 1992 (referred to in this paragraph G.1.h. of this Chapter as the "base period").

(2) For purposes of comparison to Medicare allowable payment amounts pursuant to paragraph G.1.c. of this Chapter, the Medicare national laboratory payment limitation amounts shall be used.

(3) For purposes of establishing laboratory service local CMACs pursuant to paragraph G.1.d. of this Chapter, the adjustment factor shall equal the ratio of the local average charge (standardized for the distribution clinical laboratory services) to the national average charge for all clinical laboratory services during the base period.

(4) For purposes of a special locality-based phase-in provision similar to that estasblished by paragraph G.1.d.(2) of this Chapter, the CMAC in a locality will not be less than 85 percent of the maximum charge level in effect for that locality during the base period.

i. The allowable charge for physician assistant services other than assistant-at-surgery may not exceed 85 percent of the allowable charge for a comparable service rendered by a physician performing the service in a similar location. For cases in which the physician assistant and the physician perform component services of a procedure other than assistant-at-surgery (e.g., home, office or hospital visit), the combined allowable charge for the procedure may not exceed the allowable charge for the procedure rendered by a physician alone. The allowable charge for physician assistant services performed as an assistant-at- surgery may not exceed 65 percent of the allowable charge for a physician serving as an assistant surgeon when authorized as CHAMPUS benefits in accordance with the provisions of Chapter 4 C.3.c. of this Part. Physician assistant services must be billed through the employing physician who must be an authorized CHAMPUS provider.

j. A charge that exceeds the CHAMPUS Maximum Allowable charge can be determined to be allowable only when unusual circumstances or medical complications justify the higher charge. The allowable charge may not exceed the billed charge under any circumstances.

2. All-inclusive rate. Claims from individual health-care professional providers for services rendered to CHAMPUS beneficiaries residing in an RTC that is either being reimbursed on an all-inclusive per diem rate, or is billing an all-inclusive per diem rate, shall be denied; with the exception of independent health-care professionals providing geographically distant family therapy to a family member residing a minimum of 250 miles from the RTC or covered medical services related to a nonmental health condition rendered outside the RTC. Reimbursement for individual professional services is included in the rate paid the institutional provider.

3. Alternative method. The Director, OCHAMPUS, or a designee, may, subject to the approval of the ASD(HA), establish an alternative method of reimbursement designed to produce reasonable control over health care costs and to ensure a high level of acceptance of the CHAMPUS-determined charge by the individual health-care professionals or other noninstitutional health-care providers furnishing services and supplies to CHAMPUS beneficiaries. Alternative methods may not result in reimbursement greater than the allowable charge method above.

I. REIMBURSEMENT UNDER THE MILITARY-CIVILIAN HEALTH SERVICES PARTNERSHIP PROGRAM

The Military-Civilian Health Services Partnership Program, as authorized by Section 1096, Chapter 55, Title 10, provides for the sharing of staff, equipment, and resources between the civilian and military health care system in order to achieve more effective, efficient, or economical health care for authorized beneficiaries. Military treatment facility commanders, based upon

the authority provided by their respective Surgeons General of the military departments, are responsible for entering into individual partnership agreements only when they have determined specifically that use of the Partnership Program is more economical overall to the Government than referring the need for health care services to the civilian community under the normal operation of the CHAMPUS Program. (See Section P. of Chapter 1, for general requirements of the Partnership Program.)

1. Reimbursement of institutional health care providers. Reimbursement of institutional health care providers under the Partnership Program shall be on the same basis as non-Partnership providers.

2. Reimbursement of individual health-care professionals and other non-institutional health care providers. Reimbursement of individual health care professional and other non-institutional health care providers shall be on the same basis as non-Partnership providers as detailed in Section G. of this chapter.

J. ACCOMMODATION OF DISCOUNTS UNDER PROVIDER REIMBURSEMENT METHODS

1. General rule. The Director, OCHAMPUS (or designee) has authority to reimburse a provider at an amount below the amount usually paid pursuant to this chapter when, under a program approved by the Director, the provider has agreed to the lower amount.

2. Special applications. The following are examples of applications of the general rule; they are not all inclusive.

a. In the case of individual health care professionals and other noninstitutional providers, if the discounted fee is below the provider's normal billed charge and the prevailing charge level (see section G. of this chapter), the discounted fee shall be the provider's actual billed charge and the CHAMPUS allowable charge.

b. In the case of institutional providers normally paid on the basis of a pre-set amount (such as DRG-based amount under subsection A.1. of this chapter or per-diem amount under subsection A.2. of this chapter), if the discount rate is lower than the pre-set rate, the discounted rate shall be the CHAMPUS-determined allowable cost. This is an exception to the usual rule that the pre-set rate is paid regardless of the institutional provider's billed charges or other factors.

3. Procedures.

a. This section only applies when both the provider and the Director have agreed to the discounted payment rate. The Director's agreement may be in the context of approval of a program that allows for such discounts.

b. The Director of OCHAMPUS may establish uniform terms, conditions and limitations for this payment method in order to avoid administrative complexity.

K. OUTSIDE THE UNITED STATES

The Director, OCHAMPUS, or a designee, shall determine the appropriate reimbursement method or methods to be used in the extension of CHAMPUS benefits for otherwise covered medical services or supplies provided by hospitals or other institutional providers, physicians or other individual professional providers, or other providers outside the United States.

L. IMPLEMENTING INSTRUCTIONS

The Director, OCHAMPUS, or a designee, shall issue CHAMPUS policies, instructions, procedures, and guidelines, as may be necessary to implement the intent of this chapter.

CHAPTER 20

CONTINUED HEALTH CARE BENEFIT PROGRAM (CHCBP)

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(3) Would not otherwise be eligible for any benefits under 10 U.S.C chapter 55.

(c) A person who:

(1) Is an unremarried former spouse of a member or former member of the armed forces;

(2) On the day before the date of the final decree of divorce, dissolution, or annulment was covered under a health benefits plan under 10 U.S.C. chapter 55, or transitional health care under 10 U.S.C. chapter 58, section 1145(a) as a dependent of the member or former member; and,

(3) Is not a dependent of the member or former member under 10 U.S.C. 1072, subparagraphs (F) or (G) or ends a one-year period of dependency under 10 U.S.C. 1072(2), subparagraph (h).

2. Effective date. Except for the special transitional provisions in paragraph R. of this section, eligibility in the CHCBP is limited to individuals who lost their entitlement to regular military health services system benefits on or after October 1, 1994.

3. Notification of eligibility.

a. The Department of Defense and the other Uniformed Services (National Oceanic and Atmospheric Administration (NOAA), Public Health Service (PHS), Coast Guard) will notify persons eligible to receive health benefits under the CHCBP.

b. In the case of a member who becomes (or will become) eligible for continued coverage, the Department of Defense shall notify the member of their rights for coverage as part of preseparation counseling conducted under 10 U.S.C: 1142.

c. In the case of a child of a member or former member who becomes eligible for continued coverage:

(1) The member or former member may submit to the Third Party Administrator a notice of the child's change in status (including the child's name, address, and such other information needed; and

(2) The Third Party Administrator, within 14 days after receiving such information, will inform the child of the child's rights under section 1142.

d. In the case of a former spouse of a member or former member who becomes eligible for continued coverage, the Third Party Administrator will notify the individual of eligibility for CHCBP when he or she declares the change in marital status to a military personnel office.

4. Election of coverage.

a. In order to obtain continued coverage, written election by eligible beneficiary must be made, within a prescribed time period. In the case of a member discharged or released from active duty (or full time National Guard duty), whether voluntarily or involuntarily; an unremarried spouse of a member or former member; or a child emancipated from a member or former member, the written election shall be submitted to the Third Party Administrator before the end of the 60-day period beginning on the later of:

(1) The date of the discharge or release of the member from active duty or full-time National Guard duty;

(2) The date on which the period of transitional health care applicable to the member under 10 U.S.C. 1145(a) ends;

(3) In the case of an unremarried former spouse of a member or former member, the date the one-year extension of dependency under 10 U.S.C. 1072(2)(H) expires; or

(4) The date the member receives the notification of eligibility.

b. A member of the armed forces who is eligible for enrollment under paragraph (d)(1)(i) of this section may elect self-only or family coverage. Family members who may be included in such family coverage are the spouse and children of the member.

5. Enrollment. Enrollment in the Continued Health Care Benefit Program will be accomplished by submission of an application to a Third Party Administrator (TPA). Upon submittal of an application to the Third Party Administrator, the enrollee must submit proof of eligibility.

a. One of the following types of evidence will validate eligibility for care:

(1) A Defense Enrollment Eligibility Reporting System (DEERS) printout which indicates the appropriate sponsor status and the sponsor's and dependent's eligibility dates;

(2) A copy of a verified and approved DD Form 1172, "Application for Uniformed Services Identification and Privilege Card";

(3) A front and back copy of a DD Form 1173, "Uniformed Services Identification and Privilege Card" overstamped "TA" for Transition Assistance Management Program; or

(4) A copy of a DD Form 214 - "Certificate of Release or Discharge from Active Duty".

6. Period of coverage. CHCBP coverage may not extend beyond:

a. For a member discharged or released from active duty (or full time National Guard duty), whether voluntarily or involuntarily, the date which is 18 months after the date the member ceases to be entitled to care under 10 U.S.C. 1074(a) and any transitional care under 10 U.S.C. 1145.

b. In the case of an unmarried dependent child of a member or former member, the date which is 36 months after the date on which the person first ceases to meet the requirements for being considered an unmarried dependent child under 10 U.S.C 1072(2)(D).

c. In the case of an unremarried former spouse of a member or former member, the date which is 36 months after the later of:

(1) The date on which the final decree of divorce, dissolution, or annulment occurs; or

(2) If applicable, the date the one-year extension of dependency under 10 U.S.C. 1072(2)(H) expires.

d. In the case of an unremarried former spouse of a member or former member, whose divorce occurred prior to the end of transitional coverage, the period of coverage under the CHCBP is unlimited, if:

(1) Has not remarried before the age of 55; and

(2) Was enrolled in the CHCBP as the dependent of an involuntarily separated member during the 18-month period before the date of the divorce, dissolution, or annulment; and

(3) Is receiving a portion of the retired or retainer pay of the member or former member or an annuity based on the retainer pay of the member; or

(4) Has a court order for payment of any portion of the retired or retainer pay; or

(5) Has a written agreement (whether voluntary or pursuant to a court order) which provides for an election by the member or former member to provide an annuity to the former spouse.

e. For the beneficiary who becomes eligible for the Continued Health Care Benefit Program by ceasing to meet the requirements for being considered an unmarried dependent child of a member or former member, health care coverage may not extend beyond the date which is 36 months after the date the member becomes ineligible for medical and dental care under 10 U.S.C. 1074(a) and any transitional health care under 10 U.S.C. 1145(a).

f. Though beneficiaries have sixty-days (60) to elect coverage under the CHCBP, upon enrolling, the period of coverage must begin the day after entitlement to a military health care plan (including transitional health care under section 1145(a)) ends.

E. CHCBP BENEFITS.

1. In general. Except as provided in paragraph E.2. of this section, the provisions of section 199.4 shall apply to the CHCBP as they do to CHAMPUS.

2. Exceptions. The following provisions of section 199.4 are not applicable to the Continued Health Care Benefit Program:

a. Paragraph (a)(2) concerning eligibility:

b. All provisions regarding nonavailability statements or requirements to use facilities of the Uniformed Services.

3. Beneficiary liability. For purposes of CHAMPUS deductible and cost sharing requirements and catastrophic cap limits, amounts applicable to the categories of beneficiaries to which the CHCBP enrollee last belonged shall continue to apply, except that for separating active duty members, amounts applicable to dependents of active duty members shall apply.

F. AUTHORIZED PROVIDERS. The provisions of section 199.6 shall apply to the CHCBP as they do to CHAMPUS.

G. CLAIMS SUBMISSION, REVIEW, AND PAYMENT. The provisions of section 199.7 shall apply to the CHCBP as they do to CHAMPUS, except that no provisions regarding nonavailability statements shall apply.

H. DOUBLE COVERAGE. The provisions of section 199.8 shall apply to the CHCBP as they do to CHAMPUS.

I. FRAUD, ABUSE, AND CONFLICT OF INTEREST. Administrative remedies for fraud, abuse and conflict of interest. The provisions of section 199.9 shall apply to the CHCBP as they do to CHAMPUS.

J. APPEAL AND HEARING PROCEDURES. The provisions of section 199.10 shall apply to the CHCBP as they do to CHAMPUS.

K. OVERPAYMENT RECOVERY. The provisions of section 199.11 shall apply to the CHCBP as they do to CHAMPUS.

L. THIRD PARTY RECOVERIES. The provisions of section 199.12 shall apply to the CHCBP as they do to CHAMPUS.

M. PROVIDER REIMBURSEMENT METHODS. The provisions of section 199.14 shall apply to the CHCBP as they do to CHAMPUS.

N. PEER REVIEW ORGANIZATION PROGRAM. The provisions of section 199.15 shall apply to the CHCBP as they do to CHAMPUS.

O. PREFERRED PROVIDER ORGANIZATION PROGRAMS AVAILABLE. Any preferred provider organization program under this part that provides for reduced cost sharing for using designated providers, such as the "TRICARE Extra" option under section 199.17, shall be available to participants in the CHCBP as it is to CHAMPUS beneficiaries.

P. SPECIAL PROGRAMS NOT APPLICABLE.

1. In general. Special programs established under this Part that are not part of the basic CHAMPUS program established pursuant to 10 U.S.C. 1079 and 1086 are not, unless specifically provided in this section, available to participants in the CHCBP.

2. Examples. The special programs referred to in paragraph (p)(1) of this section include:

a. The Program for the Handicapped under section 199.5;

b. The Active Duty Dependents Dental Plan under section 199.13;

c. The Supplemental Health Care Program under section 199.16; and

d. The TRICARE Enrollment Program under section 199.17, except for TRICARE Extra program under that section.

3. Exemptions to the restriction. In addition to the provision to make TRICARE Extra available to CHCBP beneficiaries, the following two demonstration projects are also available to CHCBP enrollees:

a. Home Health Care Demonstration; and

b. Home Health Care-Case Management Demonstration.

Q. PREMIUMS.

1. Rates. Premium rates will be established by the Assistant Secretary of Defense (Health Affairs) for two rate groups - individual and family. Eligible beneficiaries will select the level of coverage they require at the time of initial enrollment (either individual or family) and pay the appropriate premium payment. The rates are based on Federal Employee Health Benefit Program employee and agency contributions required for a comparable health benefits plan, plus an administrative fee. The administrative fee, not to exceed ten percent of the basic premium amount, shall be determined based on actual expected administrative costs for administration of the program. Premiums may be revised annually and shall be published annually for each fiscal year. Premiums will be paid by enrollees quarterly.

2. Effects of failure to make premium payments. Failure by enrollees to submit timely and proper premium payments will result in denial of continued enrollment and denial of payment of medical claims. Premium payments which are late 30 days or more past the start of the quarter for which payment is due will result in the ending of beneficiary enrollment. Beneficiaries denied continued enrollment due to lack of premium payments will not be allowed to reenroll. In such a case, benefit coverage will cease at the end of the ninety day (90) period for which a premium payment was received. Enrollees will be held liable for medical costs incurred after losing eligibility.

R. TRANSITIONAL PROVISIONS.

1. There will be a sixty-day period of enrollment for all eligible beneficiaries (outlined in paragraph D.1. of this section) whose entitlement to regular military health services system coverage ended on or after August 2, 1994, but prior to the CHCbp implementation on October 1, 1994.

2. Enrollment in the U.S. VIP program may continue up to October 1, 1994. Policies written prior to October 1, 1994, will remain in effect until the end of the policy life.

3. On or after the October 1, 1994, implementation of the Continued Health Care Benefit Program, beneficiaries who enrolled in the U.S. VIP program prior to October 1, 1994, may elect to cancel their U.S. VIP policy and enroll in the CHCBP.

4. With the exception of persons enrolled in the U.S. VIP program who may convert to the CHCBP, individuals who lost their entitlement to regular military health services system coverage prior to August 2, 1994, are not eligible for the CHCBP.

S. PROCEDURES. The Director, OCHAMPUS, may establish other rules and procedures for the administration of the Continued Health Care Benefit Program.

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